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ABSTRACT

This document contains prepared statements, articles, and publications from the Congressional hearing on parental involvement with adolescents in crisis. The prepared statements include those by representatives of the Department of Health and Human Services, the Christian Medical Society, the National Federation of Parents for Drug-Free Youth, the National Family Planning and Reproductive Health Association, Teen-Aid, the Search Institute, the Alliance for the Mentally Ill, and medical professionals and educators. Topics covered include alcohol abuse, drug dependence, premature sexual involvement, and mental illness. Articles and publications provided include information from 1980, 1982, and 1983 Gallup Polls, a Senate resolution supporting parental involvement with adolescent problems, and a national study on young adolescents and their parents. (BL)

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S. Hrg. 98-903

ADOLESCENTS IN CRISIS: PARENTAL INVOLVEMENT

ED249456

HEARING

BEFORE THE

SUBCOMMITTEE ON FAMILY AND HUMAN SERVICES

OF THE

COMMITTEE ON
LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

NINETY-EIGHTH CONGRESS

SECOND SESSION

ON

EXAMINING HOW BEST TO HELP ADOLESCENTS WITH PROBLEMS OF ALCOHOL ABUSE, DRUG DEPENDENCE, PREMATURE SEXUAL INVOLVEMENT, AND MENTAL ILLNESS

FEBRUARY 24, 1984

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ADOLESCENTS IN CRISIS: PARENTAL INVOLVEMENT

FRIDAY, FEBRUARY 24, 1984

U.S. SENATE,
SUBCOMMITTEE ON FAMILY AND HUMAN SERVICES,
OF THE COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:10 a.m., in room SD-628, Dirksen Senate Office Building, Hon. Jeremiah Denton (chairman of the subcommittee) presiding.

Present: Senator Denton.

OPENING STATEMENT OF SENATOR DENTON

Senator DENTON. This hearing will please come to order.

Good morning. I would like to welcome all of our guests to the first hearing of the Subcommittee on Family and Human Services, during the 2d session of the 98th Congress.

The title of this morning's hearing is "Parental Involvement With Their Adolescents in Crisis: The Federal Government's Response."

During the next few hours, we will have the opportunity to hear from professionals, parents, and attorneys on the subject of how we can best help adolescents with the problems of alcohol abuse, drug dependence, premature sexual involvement, and mental illness.

Specifically, our witnesses will address the questions of how parents can help prevent or remedy these problems.

Our hearing is an ambitious undertaking. Few are more aware than I am of the complexity of the issues before us. For example, just to ask what we can do to reduce adolescent alcohol abuse alone is to encounter a bewildering number of educational, social, legal, and moral questions. The same holds true for any of the other adolescent social crises that we will be addressing.

Moreover, we know that parents often find it difficult to deal directly with their teenage children about their problems. For example, parents are often embarrassed to talk with their teenages about sexual decisionmaking; fear of facing the fact that the children are becoming dependent on alcohol or drugs can often paralyze parents, preventing them from taking effective action. Similarly, parents may be left ignorant of the do's and don'ts of dealing with their children who are mentally ill, if they are not involved by the professionals in the treatment process.

Finding solutions to today's especially difficult adolescent crises should include more parental involvement. We know that drug and alcohol abuse, sexual activity, and adolescent mental illness are problems that each generation has faced, but during the last two decades, things appear to have gotten worse, rather than better. I am aware of and encouraged by the fact that all is not gloom. The majority of young people leave adolescence with little but pleasant memories and expectations of future success. Others, who for a time may have been caught up in aberrant or illegal behavior, change their activities and make a smooth transition into the adult world.

For some, however, the pain and turbulence caused by drug and alcohol abuse, mental illness, or premature sexual activity, follow them into adulthood.

As an example of the pain and suffering of the type we are talking about, we need only look to our city streets, where men and women call heating grates their homes. A large proportion of these people are the victims of a Government policy of deinstitutionalization of the mentally ill, which has sent mentally incompetent and mentally unstable people onto the streets without necessary support and supervision. This is an area of Federal policy which concerns me, personally, and I believe we must examine the policy of deinstitutionalization to ensure that adequate support services for the mentally ill remain available.

Whatever Government may do, the family remains our first line of defense in combatting the problems our adolescents are having. It is the question of how Government can work with parents to help their adolescents in crisis that brings us here today. We recognize that too many children today are neglected, or even abandoned, by their parents. Fortunately, troubled adolescents are not forgotten or simply written off by our society. Despite some reductions in funding, the long-term trends in Government and private spending indicate a willingness to allocate more resources toward the problems faced by troubled adolescents. I favor this trend, because I believe that community agencies, community alcohol centers, alcoholism councils, mental health centers, and adolescent family life clinics can play a useful role in educating our families and helping our children.

I believe that Federal Government policy must not ignore the crux of the issue--that is, whether this policy should exclude or encourage parental involvement in the decisionmaking process of adolescents that can lead them to engage in activities that are destructive to their health and well-being, and contrary to the values of their parents, and sometimes contrary to State and Federal laws.

To explore the attitudes of parents, children, and the public toward parental involvement in the range of social problems, we have solicited the results of several Gallup polls, which I will discuss later, and we will hear testimony from the President of the Search Institute.

I must say that the results of those polls and the information from the Search Institute indicate some different impressions than those transmitted through the media and by those who have a slightly different opinion from myself on this issue. I do not want to impose my beliefs on others, nor do I think others should be able to impose their beliefs, but some set of beliefs has to exist, some set of behavioral mores established, and they should not be based on inaccuracies about what public opinion is. These polls are going to show us today that public opinion is not as it has been represented in too many cases.

To assess the nature of both public and private efforts encourageing parental involvement in drug and alcohol, mental health, and adolescent sexuality programs, we have invited representatives of parent and patient groups as well as practicing professionals. Finally, we will hear from two attorneys with differing views about the legal issues involved in the recent administration effort to involve parents in the decisions of their children to seek prescription birth control drugs or devices.

I believe that every House and Senate Member I have had discussions with on these overall issues would be in agreement with everything I have said prior to this moment.

I would like to add my personal opinion, that the decision by the Department of Justice not to appeal the parental notification regulation suit to the Supreme Court is a grave disappointment to most American families. I regret that federally supported family planning clinics can continue to provide both sexuality counseling and prescription contraceptives to adolescents without parental notification or involvement, and yet, ironically, most adolescents must have their parents' permission to receive aspirin from a school dispensary. I find that anomalous.

Although the question of parental involvement in family planning clinics will be discussed by our final panel this morning, I intend to address the issue in detail with those who, in good will, disagree with me, when the Title X Family Planning Program is the subject of reauthorization hearings later this spring

Today's broader examination of parental involvement should help the subcommittee to weigh the efficacy and wisdom of a possible "sense of the Senate" resolution, expressing the view that, in most instances, parents have the right, and must be permitted to enjoy the privilege of being involved in federally-supported treatment, counseling and prevention efforts that are directed toward their own children.

[The resolution referred to follows:]

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98th CONGRESS
2d Session
S. RES. ______

IN THE SENATE OF THE UNITED STATES

Mr. Denton submitted the following resolution; which was ______

RESOLUTION

To express the sense of the Senate that parents of adolescents should be involved in the care, treatment, and counseling of adolescents served by Federal assistance programs.

Whereas constitutional interpretation has consistently recognized as basic in the structure of our society the claim of parental authority in the household to direct the rearing of children;

Whereas parents have the primary responsibility for the education, health, safety, and general well-being of their children, with support from churches, schools, and other community institutions;

Whereas the focus of many Government assistance programs also recognizes the importance of the family, with Head Start, education for all handicapped children, child welfare services, and compensatory education programs being just a few successful examples;

Whereas there have been exceptions to this Government recognition of the importance of the family and in some areas the Government has appeared to take the position that families are not important and are not to be involved;

Whereas parental involvement and support can be instrumental in helping adolescents overcome the problems of drug dependence, alcohol abuse, mental illness, early sexual intercourse, or unplanned pregnancy; and

Whereas the Congress should properly conclude that parents who wish to assist their children during periods of crisis are entitled to the support of the laws designed to aid their children: Now, therefore, be it

Resolved, That it is the sense of the Senate that--

(1) the Congress should support all reasonable efforts to ensure that the parents or guardians of an unemancipated minor are informed of and involved in the treatment, care, or counseling provided to such minor by an agent or grantee of the Federal Government;

(2) Except in cases when--

(A) the notification about the receipt of treatment, care, or counseling by an agent or grantee of the Federal Government would result in physical harm to the unemancipated minor by the parents or guardians;

(B) a Federal or State court has found that--

(i) the parents or guardians of an unemancipated minor are unfit; or

(ii) the conduct or condition of the parents or guardians of an unemancipated minor demonstrates that such parents or guardians are unable to properly care for the unemancipated minor;

(C) there is an overriding public health necessity of ensuring the prevention of the spread of an infectious disease; or

(D) there is a threat to the life or well-being of the unemancipated minor requiring immediate medical or protective intervention.

Senator **Denton**. Let me close by affirming my agreement with many American parents who believe that they must have primary responsibility for the care, health, and well-being of their own minor children. I hold that view, not only because I believe it to be sound from a legal and moral standpoint, but also because I believe that greater reliance on parental involvement can help prevent many of the problems and much of the unhappiness that adolescents would otherwise encounter. And I hate to see Government policy which ignores or denies that observation.

In 1980, Dr. Robert Dupont, former Director of the National Institute on Drug Abuse, wrote, quote, "The most important new frontier in the primary prevention of drug abuse"—and he means adolescent drug abuse—"is parent power. It is ironic that after a decade of parent putdowns, that we are today rediscovering that parents, who were written off as ignorant and meddlesome, at best, and as the problem, at worst, are now seen as a solution to drug problems."

Personally, I do not want to introduce the idea of parent power versus children power. I like to see it as family power, myself. I believe that there exists a union of love between parents and children, and communication and misunderstanding problems can be cleared up if only we are brave enough to face the facts as they are.

I am looking forward to hearing how family power is emerging as a new force in the prevention and treatment of all of the problems that we are considering here today.

Senator Hatch is out of town, but he asked that I express to the audience and for the record, his own strong support of this hearing.

Senator **Denton**. We are indebted, in the pursuit of our purpose of legislating so as to promote the general welfare and to help all of us pursue happiness, to those of you who have agreed to testify this morning.

I will acknowledge that I am deeply disappointed that we will not be joined this morning by an administration witness. Secretary Heckler of the Department of Health and Human Services was invited to be our lead-off witness this morning. While travel commitments prevented her from being here, I deeply regret that she decided not to send an official from her department in her stead. I believe that today's hearing is an important one for the Subcommittee and the Nation, as it continues in the perspective of the degree and advisability or inadvisability of parental involvement in various problems. I think it is a critically important subject. After the extended and polarized debate, and subsequent defeat in the courts, of the administration's parental notification regulation—which was not my initiative, but Secretary Schweiker's, and one which was backed by the President of the United States—I believe that the subcommittee and the President and his administration need to continue to review carefully the entire range of services to adolescents in crisis, to see what common ground can be developed on the issue of parental involvement.

I am going to try to prove that I will not make this subject an embarrassment in an election year, as a Republican, and I can understand if that might have been the interpretation placed on this hearing by those who chose not to send someone from HHS. I disagree with it, however. I think the subject is something that Democrats, Republicans, conservatives and liberals can address, must address, and do so in good spirit, and I would say again that the participation of the Department of HHS in today's hearing would have added a useful dimension. We are going to hear some excellent presentations, which I wish those witnesses would have been here to hear themselves. However, we will submit the Department's written letter, which frankly is not much, for the written hearing record. Written testimony is also being prepared for submission.

[The following was received for the record:]

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

February 23, 1984

The Honorable Jeremiah Denton
Chairman
Subcommittee on Family and Human Services
Committee on Labor and Human Resources
United States Senate
Washington, D.C. 20510

Dear Senator Denton:

Thank you for your invitation to provide testimony for the Subcommittee on Family and Human Services February 24 hearing on "Parental Involvement with Their Adolescents in Crisis: The Federal Government's Position."

I believe parents are the most important influence in the lives and destinies of their children. Our Nation has always recognized that parents have the primary responsibility for providing guidance and support to their children. As you know, HHS has several programs that deal with adolescents in crisis situations. These include alcohol, drug abuse and mental health counseling programs and the Adolescent Family Life program. In these programs we recognize and are very sensitive to the importance of the family. Our policies must continually emphasize and support the role of parents and family in the raising and nurturing of our Nation's most precious asset--our children. Additionally, I believe we all have a responsibility to promote maximum communication between parents and their children.

I appreciate your sharing a draft of the resolution with me. We will be forwarding at a later date a statement concerning our many programs which affect adolescents and their families.

Sincerely,

Margaret M. Heckler

Margaret M. Heckler
Secretary

"Parental Involvement with their Adolescents in Crisis: The Federal Government's Position"

Testimony for the Record

Margaret M. Heckler

Secretary

Department of Health and Human Services

Submitted to the Subcommittee on Family and Human Services
Committee on Labor and Human Resources

United States Senate

February 24, 1984

I appreciate this opportunity to submit for the record the Administration's views on parental involvement with their adolescents in crisis, and a description of some of our programmatic activities in this area.

I would like to state at the outset that the Department believes that parents have primary responsibility for the well-being of their offspring. Parents should, and most parents do, play an important role in the lives of their children during their formative years. This is especially important when a crisis occurs and a child is in need of guidance and support. The Department of Health and Human Services has several programs that deal with adolescents in crisis. These include the Adolescent Family Life and Family Planning programs, Alcohol, Drug Abuse, and Mental Health programs, and the Runaway and Homeless Youth program. In these programs we recognize and are very sensitive to the importance of the family.

Given a responsibility to promote maximum communication between parents and their children, the Department's activities include program and policy choices that involve parents in decisions to the fullest extent possible; research and demonstrations on the interaction between adolescents and parents in crucial life decisions; and informational and educational material to encourage communication in these vital areas.

Adolescent Family Life and Family Planning Programs

Adolescent pregnancy and adolescent sexuality are areas in which parental involvement can make a substantial and positive contribution. Findings from research indicate that parental involvement can have a positive impact in helping adolescents cope with the frequently negative consequences associated with adolescent pregnancy and parenthood, and in encouraging teens to postpone early sexual activity. Studies have shown that when pregnant adolescents remain with their parents, they are more likely to further their education and achieve a higher socio-economic status than do pregnant teens who leave home before or immediately after delivery. The pregnant adolescent's mother often becomes a major source of emotional support, child care, and instruction about parenting. Other studies have shown that the greater the amount of discussion within the family about topics concerning sexuality, the more likely that female adolescents will postpone sexual activity. Additional research finds that the quality of the mother-daughter relationship is an important factor in an adolescent postponing sexual activity. Finally, educational programs for parents that result in improved parent-child communication appear to increase the likelihood that teens will either postpone sexual activity or be more responsible users of contraceptives.

Both the Adolescent Family Life (AFL) Program and the Family Planning Program (FPP) deal with these issues. Both promote and encourage parental involvement in a number of activities. Model demonstration programs in the AFL Program which offer care services to pregnant adolecents encourage family involvement in a number of ways. Parents of pregnant adolescents attend prenatal classes with their children, receive family counseling, and learn information about parenting skills and adoption. These services assist parents in dealing with their daughter's pregnancy and enable them to provide emotional and practical support to the adolescent and other members of the family as they deal with the short and long-term consequences of teen pregnancy. The AFL Program also funds projects that evaluate a variety of prevention approaches to encourage unmarried adolescents to postpone sexual activity. Activities in these projects include classes and counseling to improve general communication skills between parents and adolescents, and curricula to assist parents in communicating and instructing their children about sexuality.

In addition to funding model demonstration projects, the AFL Program funds research projects. Several of these are examining the role of the family. For example, one project is analyzing a national sample in which parents and adolescents were interviewed to determine why some adolescents, but not others, become sexually active. Other projects are examining parental attitudes toward premarital sex and communication of parental values to their children. Still other researchers are examining the role of the family and other factors that influence the pregnant teenager's decisionmaking process to parent her child or to arrange for an adoption.

In the Family Planning Program, each grantee has been given guidance to ensure that they have the following parental involvement elements in their program: A policy which supports the involvement of parents in the delivery of family planning services to their children; and specific objectives which will increase the involvement of parents of the adolescent clientsin their clinics. In addition, a parental involvement seminar is being provided for all governing board or advisory council members of family planning clinics.

The Office of Family Planning is also producing materials to promote parental involvement. One project is developing bilingual, bicultural parental involvement materials based on Hispanic family traditions to assist Hispanic parents communicate their values and provide factual information to their children. Another project is reviewing all of the materials produced under Federal sponsorship over the past decade on the subject of adolescent sexuality. There is wide interest in the availability of materials which will encourage adolescents to postpone sexual activity and will help parents to communicate their attitudes and information regarding sexuality to their children. By identifying and evaluating what already exists on these topics, the Office of Family Planning will be in a position to know what is already available and will be helpful, what can be easily modified, and what new materials should be produced.

Alcohol, Drug Abuse, and Mental Health Programs

There are a wide assortment of alcohol, drug abuse, and mental health treatment programs available in all States. Counseling in these programs is provided by various types of health care personnel such as psychiatrists, psychologists, social workers, alcohol and/or drug abuse counselors, and psychiatric nurses. There is no Federal policy on counseling. All of these health care personnel must meet whatever State licensure requirements are in effect where their facility or practice is located.

An important role to be played by parents is in prevention. It is far better to prevent young people from developing these conditions than to deal with the tragic consequences. The long-term mission of the Alcohol, Drug Abuse, and Mental Health Administration is to play a knowledge development, technical assistance, and information dissemination role in prevention and to rely upon the block grant, States/local communities, and voluntary organizations for actual program operation and funding. We believe that within these activities there are four major groups as foci: parents, schools, community-based programs, and youth themselves. Action is necessary at all of these focal points to assure a coordinated effort to discourage youth from inappropriate behavior with alcohol and drugs, and to recognize and intervene in mental health problems before they reach a crisis stage.

Let me briefly list some of the Department's important activities in these fields.

Alcohol

In 1982, the Inspector General of the Department of Health and Human Services issued a report on the extent of the teenage alcohol abuse problem in the United States. As a result, the Secretarial Initiative on Teenage Alcohol Abuse was launched with the National Institute on Alcohol Abuse and Alcoholism designated as the lead agency. Major components of the Initiative which involve parents include:

- In the fall of 1982, a series of 10 regional conferences on prevention and early intervention were held across the country for school personnel, PTAs, and alcohol and drug program personnel. The 1,100 people who attended the conferences examined a variety of program models for educating youth about alcohol and drugs, including classroom education, teacher training, and parent education.
- A series of 15 regional youth alcohol treatment conferences were held across the country in the fall of 1983. The objectives of these conferences were to provide participants with information related to youth alcohol treatment programs; to build on and strengthen existing local and regional collaborative information exchange and support networks; and to identify issues, and stimulate the

development of a stronger continuum of care responsible to the special needs of youthful alcohol abusers. Approximately 3,000 people participated in the 15 conferences including parents; youth; law enforcement personnel; alcohol and drug treatment providers; health, welfare and probation workers; school superintendents and board members; national, State, and local legislators and other government officials.

- A 324-page publication, "Prevention Plus: Involving Schools, Parents and Community in Alcohol and Drug Education," presents model prevention programs which can be utilized by parents, schools, and communities to start to enhance their own programs.

Mental Health

In mental health, we are actively studying many aspects of family functioning in order to develop successful prevention and intervention strategies. We are currently sponsoring scientific workshops nationwide on such topics as:

- prevention of suicide and affective disorders among adolescents and young adults;
- preventive child psychiatry and childhood chronic illnesses;

- primary prevention of aggressive and violent behavior; and
- assessing and promoting healthy family functioning.

Additionally, the National Institute of Mental Health is sponsoring research aimed at preventing sexual abuse of children, increasing the ability of single parents to cope with child rearing, understanding the effects of divorce on children, and developing coping and supporting systems for high-risk adolescents. These workshops and papers are designed to help practitioners and community programs stay abreast of the latest research development in the field of parents, youth, and families.

Drug Abuse

Drug abuse prevention strategies and prevention research have been high priorities for the National Institute on Drug Abuse (NIDA) from its inception. We have learned through our prevention research that it is vitally important to emphasize prevention strategies targeted at teenagers and younger adolescents. We have continually evaluated these strategies which are designed to prevent, delay, and reduce the onset of drug abuse and related social behavior problems.

NIDA has supported the parents movement by lending technical assistance and publishing a variety of materials. Parents, Peers, and Pot was developed for parents' groups, and it has been the most widely requested NIDA publication. NIDA sponsored a national workshop dealing with parents and drug abuse prevention. Discussion focused on community networking, parenting skills, and other family-centered approaches to drug abuse prevention. NIDA convened 300 State prevention coordinators and parents in regional conferences designed to increase coordination among the States. There are now over 4,000 organized parents' groups working to promote an environment in which children are getting "don't do drugs" messages from parents, schools, the medical profession, and the community at large.

In addition, NIDA encourages and assists voluntary citizen efforts and has been instrumental in the formation of a national prevention coalition. The coalition, made up of volunteer and private sector organizations, such as the American Medical Association, International Lions Club, National Parent/Teacher Association, and the Rotary International, develops long-range community prevention strategies.

Increasing public awareness of drug abuse and its health consequences is a principal goal of NIDA's communications program. For many years, NIDA has produced materials that provide factual and credible information about the health consequences of drugs. During the past two years, over 7.5 million publications were distributed in response to demand from parents, young people, community programs, treatment staff, researchers, and State officials. An additional one million publications have been distributed through a national supermarket dissemination program.

In September 1983, NIDA launched a drug abuse prevention media campaign in connection with the Advertising Council. This campaign's primary focus is to promote abstinence among young people aged 12 to 14, and to enlist parental support in encouraging young people to resist peer pressure to use drugs. The film spots tell young people "It's OK to Say NO to Peer Pressure," and show them how to actually "Just Say NO." The message to parents is to get involved and talk to their children about drugs. It is important for them to know what they can do about drug abuse so that they get involved with drugs before their children do.

Runaway and Homeless Youth Program

There are an estimated 733,000 to 1.3 million youth who run away or are pushed out of their homes every year. The Runaway and Homeless Youth Program addresses the crisis needs of runaway and homeless youth and their families through support to local and State governments and non-profit agencies to develop or strengthen community-based facilities which are outside of the law enforcement structure and the Juvenile Justice system.

An important goal of the program is to reunite youth with their families and to encourage the resolution of intrafamily problems through counseling and other services. This goal is addressed, in part, through the provision of assistance to youth in re-establishing contact with their families after services are sought.

This goal is also addressed by the services provided through a National toll-free hotline. During Fiscal Year 1983, the switchboard assisted 200,000 youth and families; 26 percent of the calls involved direct contact between the youth and his/her parents or guardians.

Counseling services--individual, group, and family--and the provision of other types of support services, either directly by the runaway and homeless youth centers or through referrals to other community agencies, also address strengthening family relationships and encouraging stable living conditions.

In its report to the Congress, Federally Supported Centers Provide Needed Services for Runaways and Homeless Youth (September 26, 1983), the General Accounting Office (GAO) also substantiated the importance of the centers in reuniting families and resolving intrafamilial problems associated with runaway behavior. In its study of 17 centers, the GAO found that 93 percent of the youth interviewed and 98 percent of parents believed that their family problems would not have been resolved without the assistance of the centers.

In conclusion, I emphasize again our responsibility to promote maximum communication between parents and their children. Our policies must continually emphasize and support the role of parents and family in the raising and nurturing of our Nation's most precious asset--our children.

Senator **Denton**. I have to note that president Reagan's own strong views on the importance of the family and its primacy in society are directly related to this hearing on parental involvement, and he expressed those views for the first time in his State of the Union Address. For what it is worth, I intend that the administration have a second chance to testify within the not-too-distant future on this subject, and if I have difficulty with affording them the second chance, I shall appeal to the President himself on this matter.

I would like our first witness, Dr. Strommen, to come forward, pleased.

Dr. Strommen is the president of Search Institute. He will present the results of a recently-completed survey on "Early Adolescents and Their Parents," which examined the needs, values and concerns of 8,000 young adolescents and 10,000 of their parents.

I am please to note that the Search Institute recently received an Adolescent Family Life Grant. The Adolescent Family Life Act is a bill which I originated. It was passed unanimously in Labor and Human Resources, but is now under attack as part of this ongoing debate. After having been passed by Congress, it is now under attack by the ACLU, and some people who belong to one of the grantees in the sex counseling and contraceptive-issuing field.

So I am pleased to see that the Search Institute did receive an adolescent family life grant to develop a family-centered sex education program.

Welcome, Dr. Strommen. Please feel free to begin when you are ready.

STATEMENT OF DR. MERTON STROMMEN, PRESIDENT, SEARCH INSTITUTE, MINNEAPOLIS, MN

Dr. **Strommen**. Thank you.

I should introduce myself. I am a psychologist. I am president of Search Institute. This is a scientific and an educational agency. Its purpose is to use objective research to gain innovative knowledge needed by human service institutions. Our work tends to be in the tradition of the liberal arts, which will not ignore the areas of values and beliefs as part of that which one needs to know in understanding human behavior.

I was asked to report on the study that we have just completed, of 8,156 young adolescents, grades five through nine, and 10,467 parents of these young people. These were randomly selected from the rosters of 13 national youth-serving agencies, and in that respect, does not represent a sample of the general public, but of a major segment of the American public.

These would be the populations that youth organizations and religious institutions would be apt to reach through their programs.

In order that you might have some sense of the number of adolescents that may be at risk, even in this kind of a population, I should just indicate a few indices here of that. With respect to alcohol use in our sample, one out of five fifth-graders have begun using alcohol, and by the time of ninth grade, over half are using alcohol. By ninth grade, 34 percent of the boys would have been drunk, or 21 percent of the girls.

With respect to sexual activity, one out of five of the young people in this age group would have had sexual intercourse one or more times, and by the ninth grade, that would be 28 percent of the boys and 13 percent of the girls.

With respect to the use of marijuana, about 13 percent would have used or experimented with marijuana in the last 12 months, and 20 percent of the ninth-graders would have done so. Hard drugs, a very low incidence of use. Among ninth-graders, it would be less than 1 in 10.

I simply identify these to indicate that also in these populations, you do have adolescents at risk, and therefore, the issue of parental involvement is a vital one. The subject is so large that I would like, Mr. Chairman, to simply indicate the four areas that we have addressed through our research and identify two research conclusions in each of these areas, and then allow for the questions that were requested at the time of invitation.

I shall first identify as area number one, the families of adolescents, and two research conclusions followed it up with more specific information, should that be desired.

First of all, parents of adolescents that we studied are hopeful; they find satisfaction in parenting; they find the task difficult and are eager for help. I think it is significant here to note that 16 values sorted out as being most important for parents. In the survey, which involved well over 300 items for each of the two groups (reported thoroughly here, in a manual of 417 pages,) we found that the top value for parents is to have a happy family, and the next-to-the-top value is to be a good parent. But four out of five said, "To be a good parent is one of the hardest things I do."

Nevertheless, 88 percent indicated that almost always or most of the time, they find satisfaction in being a parent. I simply identify here, Mr. Chairman, the vitality and the strength which we have in our American family.

The second major conclusion having to do with families of adolescents is this. As children move into the adolescent period, family closeness and unity decline. This confirms another major study. If one thinks in terms of stages in family life, the fourth stage, when adolescents are in the home and of that age, family life is at its lowest ebb in terms of closeness, and in terms of communication. This period some now call the "storm and stress" stage of family life. We found that also true in our study. For instance, family or parental harmony—would be at one level for fifth grade parents, and decline measurably for the ninth grade parents. This is not because ninth grade youth are more difficult to handle than fifth grade youth. In fact, clearly, the evidence is to the contrary. There are stresses and pressures on parents at this age that are unique and cause this to be a difficult time.

More germane to this hearing is the fact that parent-youth communication drops precipitously. Fifth grade young people are very interested in discussing adolescent issues, the very things that have been mentioned by the chairman—issues that are difficult for them; 50 percent would like to discuss them with their parents. This interest tapers off toward the ninth grade. Yet even in the ninth grade, though it has dropped measurably, young people still prefer their parents for discussing adolescent issues than any other person who might be singled out.

So much for the families of adolescents. The second major area I would like to identify has to do with the type or quality of parental involvement in the life of the adolescent.

First, there are two patterns of parental control that do encourage negative behaviors in adolescence. One is an authoritarian, rigid, dominant, harsh approach to young people, and the other is a permissive one. Both have similar outcomes in terms of negative behaviors. Whereas an authoritative or democratic approach encourages positive growth and development—which points up, then, that one way by which one does enhance the life of parental involvement is to assist parents in the type of parental control which has positive effects for the future.

The second major conclusion for this area, No. 2, is this. Parental nurturance or caring is a strong deterrent to negative adolescent behaviors, and represents a positive force for healthy development. Here, in talking about nurturance or caring, we are talking about speaking to young people in an affirming way, expressing love in what one says and in how one embraces or kisses or caresses the adolescent. In homes where this is done, there is a measurable change in terms of behavior toward the positive side.

A third area represents information that is less available and more unique to our study. It has to do with the value orientation that a parent passes on to an adolescent child.

There are two conclusions I would like to give here. The first is this. The best predictor of adolescents who are willing to delay gratification are the moral beliefs that adolescents themselves hold. It is significant here that parents intuitively are aware of this importance because, in their asking for help, the one item which came to the top in terms of the most preferred type of help was help in teaching one's child healthy concepts of right or wrong. And interestingly, when young people indicated a topic they would like to discuss with their parents, it had to do with concepts of right or wrong.

The second major conclusion for this area is this. Adolescents who are the most likely to evidence a sense of moral responsibility are those who value a personal faith and are involved in the life of their congregation. Here, we would distinquish between two types of religious faith. One is moralistic, with negative effects, and the other is a religion of grace, of forgiveness, that has positive effects. The psychological literature makes frequent reference to the fact that an identification with a faith does correlate and is linked with positive behaviors.

Then, Mr. Chairman, the last area I would like to identify has to do with the significance of parental involvement in communities of support. One of the striking evidences in our study was the strong desire for outside help among the parents. They would like to be able to communicate better with their youth on adolescent issues. They would like to be able to discuss matters of alcohol and drugs, sexuality, and the like, and yet, only in a third of the homes does this kind of conversation take place. And so, the question comes, where would they turn.

So we asked them, giving them a variety of possible sources of help, their preference when in need of help. Their first choice is a clergyperson. Studies in the field of mental health have come up with the same conclusion. People troubled with mental illness, when they need help, turn first to that person or role,

My last conclusion is this. Children at risk—now, here, I am going to identify those who are in single-parent homes, whose parents retain an identification with support systems including the religious community, show few negative behaviors. Here, I draw into attention to a major study, by Gidibaldi at Kent State, who made a national study of young people in public schools and compared the children of divorced parents with those children of intact families. He was able to show the sharp impact that this traumatic experience has on boys of fifth grade. He was also able to show that this effect is mitigated where the mother—usually the mother—has been able to remain in contact with the support systems that have been a part of their past. This includes schools that are small enough and structured enough to become a support system. We find corroboration for this in our study. The single parents we studied—there were 480—are all identified with a youth-serving agency or with a religious institution. We found very few negative behaviors that would distinguish the children from this group of people, commonly seen as children at risk, from the total population.

So, Mr. Chairman, I present this as evidence of the power of the support systems that are present in the parallel institutions that we have in our communities.

This represents my initial statement.

[The following was received for the record:]

Young Adolescents and their Parents

A national study *carried out by* ***Search Institute*** *and 13 national youth-serving organizations*

FORMERLY YOUTH RESEARCH CENTER
search institute Research applied to human needs

SUMMARY OF FINDINGS

Summary of Findings

YOUNG ADOLESCENTS AND THEIR PARENTS

A national research project conducted by
Search Institute, Minneapolis
in cooperation with:

American Lutheran Church
African Methodist Episcopal Church
Baptist General Conference
Churches of God, General Conference
Evangelical Covenant Church
4-H Extension
Lutheran Church--Missouri Synod
National Association of Homes for Children
National Catholic Educational Association
Presbyterian Church in the United States
The Sunday School Board of the Southern Baptist Convention
United Church of Christ
United Methodist Church

February 1984

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I. PURPOSES AND DESIGN

The project, "Young Adolescents and Their Parents," began in 1980, with major funding provided by Lilly Endowment, Inc. The project brings together the research capability of Search Institute and the programming expertise of thirteen national youth-serving organizations. The research component included a 319-item survey given to more than 8,000 5th through 9th grade young adolescents and a different, 328-item survey administered to more than 10,000 parents of these youth.[1]

Why Is This Study Important?

The 5th through 9th grade period in the life cycle is a time of significant growth--physically, emotionally, and cognitively. It is not an easy time--for youth themselves, for parents, or for the adults in youth-serving organizations who dedicate their lives to helping young people successfully negotiate the challenges and crises of growing up in a complex world. Each of the 13 organizations involved in this project is committed to developing effective programs and resources for young adolescents and their parents. To develop these effective resources, a systematic understanding of the needs, values, and concerns of young adolescents and parents is crucial. Because so little previous research has focused on young adolescents and their families, this project was designed to fill this "information gap." As Jerome Kagan argued a decade ago, "It is a paradox that adolescence should be the period of greatest concern to parents and youth and the era least well comprehended by psychologists. Our understanding of the human infant has been enhanced enormously during the last decade as elegant methodology and rich theory were simultaneously focused on the first year. But no comparable wisdom has been accumulated for early adolescence."[2]

This new and critically needed information will be used by each of the 13 organizations for developing new resources for young adolescents and families. As a leader of one of the participating organizations has said, "The more information we can gather about these individuals--be they children, youth, or adults--the more perceptively and accurately we can design our programs and materials to meet these needs."

Too many research projects end up with interesting information which too few people hear about--information reported in a way too technical or abstract to inform program planning and development.

To help ensure that this project makes a difference for young adolescents and their families, the project incorporates the following features:

- Staff persons responsible for program planning and development in each of the 13 participating national agencies have played an active role in conceptualizing, designing, and conducting the study.

- An invitational conference, "Listening to Early Adolescents and Their Parents" (LEAP '84), is being held in Nashville, February 26-29, 1984. Four hundred persons, representing the 13 cooperating agencies, other youth-serving organizations, and the fields of law, social work, philanthropy, medicine, and education, will have an opportunity to explore the research findings, discuss program implications, and build networks for cooperative program ventures.

- The two project reports are written in non-technical language, with a focus on the needs of program planners and decision-makers. This report, Summary of Findings, is a brief overview of the major discoveries which emerge from the national research project. A three hundred page Project Report documents and discusses these findings. Both of these reports are to be released in February, 1984. Each of the 13 agencies has developed plans for disseminating project results and involving clusters of national staff people in interpreting and using the information.

- The 13 cooperating agencies will continue to work together after the official close of the project (1984). These groups intend to share resources and engage, where possible, in collaborative efforts.
- In the Fall of 1983, each of the 13 national youth-serving agencies received an agency report which compared its youth and parents to the composite samples. These reports included recommendations for program directions.

How Was the Survey Conducted?

Each of the 13 sponsoring agencies selected a random sample of its affiliated units (churches, schools, clubs, or residential care facilities). In each selected unit, the 5th-9th grade young adolescents affiliated with that local unit were invited to participate in the survey. Depending on the size of the local unit, either all or a random sample of young adolescents were selected for participation. In addition, the parents of each invited young adolescent were asked to respond to the parent survey. Surveys were administered in group settings, guided by a detailed manual which standardized the survey administration process. Careful procedures were adopted to guarantee confidentiality. A survey numbering process made it possible to later match the answer sheets of youth and their parent or parents for analysis purposes.

The survey instruments covered a wide range of topics. A list of the topics included in the young adolescent survey are as follows:

Demographics

Social Context
- School
- Friends and Peers
- Church
- Family Characteristics
- Family Dynamics
- Youth Group Involvement
- Mass Media Exposure
- Socio-Economic Indicators

Developmental Processes
- Autonomy
- Maturation and Sexuality
- Identity
- Intimacy
- Achievement
- Social Integration

Beliefs, Attitudes, and Values
- Social Attitudes
- Worries
- Moral Values
- Values
- Religion

Perspectives on Receiving Help
- Sources of Advice and Help
- Desired Programs from Youth Organizations
- Desired Communication with Parents

Behavior
- Prosocial Behavior
- Anti-social Behavior
- Alcohol and Drugs
- Dating and Sexuality

The parent survey covered similar territory with an additional focus on parenting issues.

Characteristics of the Young Adolescent and Parent Samples

Table 1 shows the sizes of the young adolescent and parent samples and the percentage of the samples that come from each of the 13 national youth-serving organizations. Because this Summary of Findings is based on the total national samples of youth and parents, it is important to characterize the nature and generalizability of these samples.

First, because 10 of the 13 participating organizations are national, Protestant church bodies, the samples are clearly weighted to families which maintain an association with a local congregation. This connection to a local congregation also characterizes the vast majority of youth and parents in the 4-H sample. Many of the residential facilities affiliated with the National Association of Homes for Children

Table 1:

Sample Sizes and Origins

Sample Sizes

Grade in school	Young Adolescents			Parents		
	Boys	Girls	Total	Mothers	Fathers	Total
5th	660	720	1,380			
6th	807	852	1,659			
7th	866	978	1,844			
8th	888	1,010	1,898			
9th	586	677	1,263			
Total	3,807	4,237	8,165 *	6,076	4,391	10,467

Sample Origins

Sponsoring Agency	Percent of Young Adolescent Sample	Percent of Mother Sample	Percent of Father Sample
African Methodist Episcopal	3%	1%	2%
American Lutheran Church	10%	14%	13%
Baptist General Conference	7%	10%	8%
Churches of God, General Conference	4%	5%	5%
Evangelical Covenant Church	6%	8%	7%
4-H Extension	14%	12%	14%
Lutheran Church--Missouri Synod	7%	9%	8%
National Association of Homes for Children	7%	0%	0%
National Catholic Educational Association	14%	8%	10%
Presbyterian Church/U.S.	5%	7%	6%
Southern Baptist Convention	8%	8%	9%
United Church of Christ	8%	9%	9%
United Methodist Church	8%	10%	9%

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* Includes 121 young adolescents, grade or sex unknown.

are church-related. However, the youth they serve are not necessarily from backgrounds that include a religious dimension.

The thirteenth organization, the National Catholic Educational Association, contributed 14 percent of the young adolescent sample, eight percent of the father sample, and ten percent of the mother sample. All the youth were enrolled in a Catholic elementary school. About 90 percent of the youth and parents surveyed by NCEA claim a Catholic religious affiliation.

Below is listed the religious affiliation of the samples and the religious affiliation of the American adult population described in a recent Gallup Poll.[3]

	SURVEY SAMPLES			NATIONAL
	Youth	Mothers	Fathers	
PROTESTANT				
Baptist	22%	20%	19%	19%
Lutheran	19%	22%	23%	6%
Methodist	14%	16%	14%	10%
Presbyterian	7%	7%	8%	4%
Other Protestant	21%	21%	23%	20%
TOTAL PROTESTANT	83%	86%	87%	59%
Roman Catholic	15%	12%	9%	28%
Jewish	>1%	>1%	>1%	2%
Other	>1%	>1%	>1%	4%
None	2%	2%	4%	7%

Compared with the national demography of religious preference, the survey samples are decidedly more Protestant and less Catholic. In the Protestant sphere one noticeable feature is the overrepresentation by Lutherans. Overall, we can say that the survey samples, though they do not precisely represent, roughly approximate the populations of youth and parents affiliated with Protestant or Catholic congregations or parishes.

Because 87 percent of Americans claim a Protestant or Catholic religious preference, and nearly 70 percent report they belong to either a Protestant or Catholic church,[4] it is tempting to conclude that the findings reported in this summary approximate the national populations of young adolescents and their parents. However, it is important to pinpoint the following:

- In most of the sites where the surveys were given, some young adolescents decided to participate, and some did not. It is likely that at the church sites, it was the more active or committed who participated. There also may be other factors not known to the researchers which distinguish participants from non-participants.
- As shown in Table 2, there are some demographic differences between the young adolescent sample and the national population of youth and families. The North Central states (a band of states that extends from Ohio to the Dakotas) are overrepresented, as is the percentage of mothers and fathers with four years or more of college. The percentages of Black and Spanish-origin youth is underrepresented, as is the percentage of youth in single-parent households. On town size distribution and family income, however, the sample is a close approximation of national figures.
- For about 2000 young adolescents, the mother did not complete the survey. For about 3500, the father did not complete the survey. Though the parent samples match the youth sample on geographical location and town size, a disproportionate number of single parents did not participate. Hence, the

Table 2: Young Adolescent Sample Compared to National Census Data

Characteristic	Young Adolescent Sample	National Census Data[5]
Region[6]		
North East	14%	22%
North Central	39%	26%
South	33%	33%
west	13%	19%
Family Income[7]		
$9,999 or less	6%	10%
$10,000 - $19,999	18%	16%
$20,000 or more	76%	74%
Race and Spanish Origin[8]		
Black	7%	15%
Asian	1%	2%
Spanish Origin	2%	8%
Town Size[9]		
Under 5,000	35%	31%
5,000 - 25,000	20%	19%
25,001 - 50,000	9%	10%
50,001 - 100,000	7%	8%
100,001 - 500,000	15%	13%
500,001 or more	14%	13%
Family		
Lives with two parents	84%	74%
Lives with mother, father absent	11%	21%
Lives with father, mother absent	1%	2%
Lives with neither mother or father	3%	3%
Mother in Labor Force[10]	59%	55%
Education[11]		
Mother with 4 years college or more	38%	13%
Father with 4 years college or more	43%	22%

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parents' samples have a smaller percentage of single parents than of youth who claim to live in a single-parent household.

In summary, it cannot be said that the characteristics described in this report pertain to all American young adolescents and their parents. But what we do have is a descriptive portrait of the kinds of youth and families many national youth-serving agencies tend to reach. This includes not only national church bodies but also secular organizatons whose clientele tend to be connected with Protestant or Catholic institutions. Furthermore, it is likely that the relationships among different sets of variables (for example, how young adolescent characteristics shift with grade in school, or with parenting style, or with whether one is a boy or girl) described in this study would not change appreciably if the samples were more nationally representative.

II. FINDINGS: YOUNG ADOLESCENTS

SOCIAL CONTEXT

School

- The majority of young adolescents have positive attitudes toward school. However, interest in school declines for both boys and girls between the 5th and 9th grades. The greatest decrease in interest in school occurs between the 5th and 7th grades.
- At all five grades (5th, 6th, 7th, 8th, 9th), girls report higher school interest than boys.
- Less than one-third of 8th and 9th graders do six hours or more of homework each week.
- For both boys and girls, school climate becomes less positive with each increment in grade.
- The number of young adolescents who perceive classmates using alcohol or marijuana at school doubles between the 8th and 9th grades. This increment is graphically portrayed in Table 3.

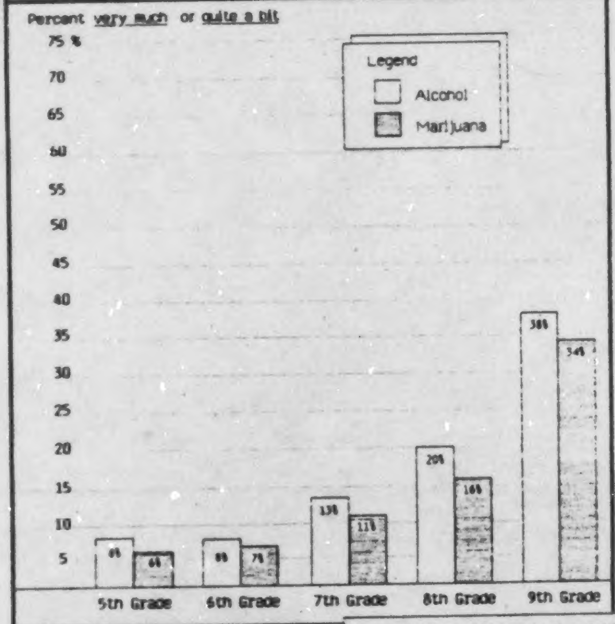
Mass Media

- Half of all the young adolescents in this study spend three hours or more each day watching television.
- Nearly one out of four (24%) devote three hours or more each week to playing videogames.
- Only one of the four forms of media exposure--rock music--increases with grade in school. Exposure to the other three forms--TV, movies, and videogames--is relatively stable between 5th and 9th grade.
- Boys and girls do not differ in the amount of time spent watching television, nor in the frequency of attending movies. However, boys spend more time than girls in listening to rock music and playing videogames.
- Young adolescents who spend significant amounts of time playing videogames behave more aggressively than those who play videogames less frequently. It is not clear whether videogames induce aggression or aggressive youth gravitate to videogames.

Church

- For both boys and girls, attitudes toward the church become less favorable between the 5th and 9th grades. By the 9th grade, however, 40 percent of boys and 51 percent of girls still report that the church is very important or extremely important to them.

Table 3:
Perception of How Much Students Use Alcohol & Marijuana at School



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How much do these things go on at your school?

Youth #244 Kids smoking marijuana (pot, grass)

Youth #246 Kids drinking alcohol (beer, wine, liquor)

Very much
Quite a bit
Some
A little
Not at all

- Thirty-eight percent of 8th and 9th graders report that "church or synagogue helps me answer important questions I have about life."

- Girls have more positive attitudes toward the church than boys. This holds true for all five grade levels.

- The more favorable a young adolescent's attitudes are toward the church, the more likely he or she is to have compassion for other people and the less likely he or she is to use drugs or alcohol or engage in anti-social behavior.

Friends and Peers

- There is a dramatic shift to greater sex-integration in friendship circles, with a rise in percentage of opposite sex friends with each advance in grade.

- There is a modest shift to greater race segregation in friendship circles, with 9th graders reporting more race segregation than 5th graders.

- Between the 5th and 9th grade, peer influence increases and parent influence decreases. However, in no grade does peer influence outweigh the influence of parents.

- In the 7th, 8th, and 9th grades, girls are more influenced by peers than boys.

- Boys experience more "peer pressure to deviance" than girls.

DEVELOPMENTAL PROCESSES

Autonomy

- The young adolescents in this project were asked to rate the importance of each of 24 values or goals. One of these was "To make my own decisions." The importance of this value changed more between the 5th and 9th grade than any of the other value statements. In other words, "To make my own decisions" grows in importance quite rapidly across the five years of early adolescence, and it grows more dramatically than any other value area. There is a noticeable rise with each advance in grade from 5th to 8th, and no significant rise occurs after 8th grade. By the 8th grade, 6 out of 10 young adolescents (62%) place high importance on autonomy. At each grade, girls report as much interest in autonomy as boys.

- Boys and girls experience equal gains in the attainment of autonomy between 5th and 9th grade.

- The amount of youth-parent conflict (defined as the degree to which young adolescents reject or question parental authority) increases between 5th and 9th grade, with a small increase with each advance in grade.

- There is no major difference between boys and girls in the degree of conflict with parents.

- Only a minority of young adolescents report major conflicts with parents. By 9th grade, fewer than 20 percent of young adolescents appear to experience strong conflict with parents.

- While parent-youth conflict does become more common by 9th grade, the phenomenon of out-and-out rebellion against parents, or rejection of parental values, is relatively rare. Autonomy-seeking by young adolescents does not necessitate or create rebellion. Though autonomy may come more slowly than young adolescents would prefer, this problem does not appear to call into serious question either the authority of parents or the affectional bonds between young adolescents and their parents.

Social Competence

- Both boys and girls increase in self-disclosure, empathy, and friendship-making skills between the 5th and 9th grade. In all three areas, girls report more competency than boys.

- Eighty-five percent of the young adolescents in this study report having three or more close friends. Only 15 percent report having two or fewer friends.

- The figure of 15 percent is also a good estimate of the number of young adolescents who experience social alienation or estrangement from others due either to a lack of social competencies or to being ostracized by others.

Identity

- At all grade levels, girls express less satisfaction with their bodies than boys, and girls' satisfaction with their bodies decreases across the five years while boys' comfort stays relatively stable.

- Because of the many changes young adolescents must adapt to, including major transitions in biological maturation, it seems reasonable to expect a major upheaval in overall self-esteem--the degree to which one feels to be a person of worth. Contrary to expectation, we find no grade-related change in self-esteem. Self-esteem remains stable across the five years for both boys and girls.

- Between 5th and 9th grades, boys experience a modest increase in a masculine sex-role orientation, and boys' feminine orientation does not change.

- Between the 5th and 9th grades, girls experience a strong increase in a feminine sex-role orientation and a modest increase in a masculine sex-role orientation.

Achievement

- At each grade level, girls report higher achievement motivation than boys.

- At each grade level, girls report higher educational aspirations than boys.

Sexuality

- By the 9th grade, 72 percent of girls have gone "almost through" or "completely through" pubertal development, according to the mothers in the survey. Only 36 percent of 9th grade boys have proceeded "almost through" or "completely through" puberty.

- The frequency of "thinking about sex" rises dramatically through the grades, with a greater increase reported by boys. This finding is shown in Table 4.

- Thirty-nine percent of 5th graders report "being in love." The percentage rises to 51 percent by 9th grade. This finding is shown in Table 5.

- In the 9th grade, 61 percent of girls are attitudinally opposed to premarital intercourse. However, only 36 percent of 9th grade boys hold the same attitude.

- Young adolescents responded to this question: "Have you ever had sexual intercourse ("gone all the way" or "made love")?" The percentages who report engaging in intercourse one or more times are:

5th	6th	7th	8th	9th
12%	16%	15%	17%	20%

The 5th and 6th grade data may be suspect, reflecting in part uncertainty about the meaning of the term "sexual intercourse." It is safe to assume that 8th and 9th graders know what is being asked. For these two grades, nearly one in five report experience with sexual intercourse.

- There is a major boy/girl difference on the intercourse item. The percentages of boys and girls who claim to have engaged in intercourse one or more times are as follows:

	7th	8th	9th
BOYS	22%	26%	28%
GIRLS	9%	9%	13%

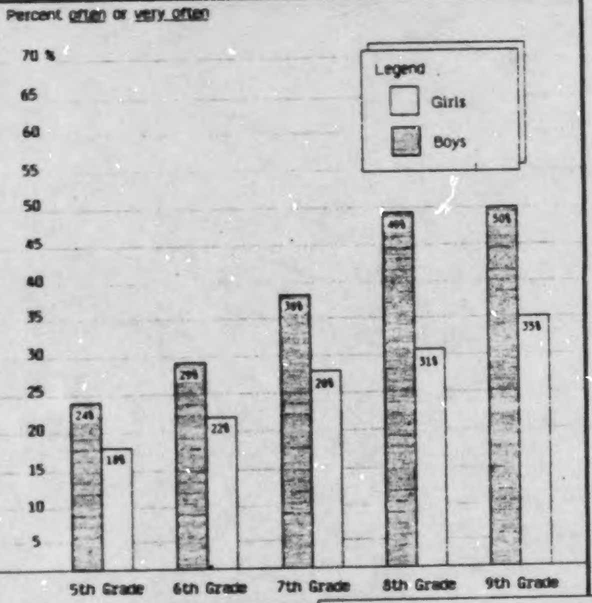
- Only about one-third of young adolescents report that they have had "good talks with my parents about sex."

WORRIES AND CONCERNS

- From a list of potential sources of worry, young adolescents worry most often about these three: "About how I'm doing in school," "About my looks," and "About how my friends treat me." The percentages for all 20 questions are shown in Table 6.

- Worry about victimization (or physical or sexual abuse) is highest among 5th graders. These kinds of worries decrease as age increases. Nearly one out of every four 5th graders worries about the possibility of sexual abuse.

Table 4:
Frequency of Thinking About Sex



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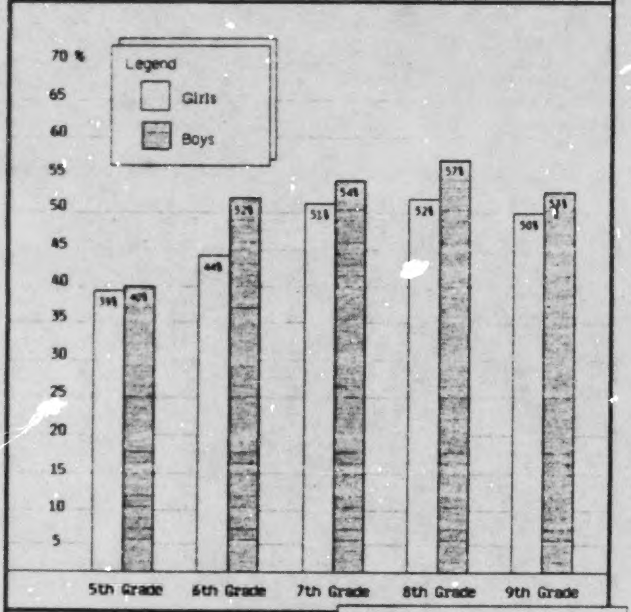
Youth #261 How often do you think about sex?

Never
Once in a while
Sometimes
Often
Very often

Table 5: Percentage of Young Adolescents Who Are "In Love"



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Youth #279 I am in love now with someone of my age who is of the opposite sex.

Yes No

Table 6:

The Worries of Young Adolescents

Percent responding very much or quite a bit

Survey Question	All Youth	5th	6th	7th	8th	9th
#208 School performance	56%	54%	54%	56%	51%	52%
#209 About my looks	53	42	48	56	60	57
#197 How well other kids like me	48	45	46	51	52	47
#203 Parent might die	47	50	48	49	46	41
#193 How my friends treat me	45	42	43	46	47	45
#204 Hunger and poverty in U.S.	38	52	41	38	32	31
#211 Violence in U.S.	36	43	37	38	33	30
#198 Might lose best friend	36	40	35	39	34	29
#202 Drugs and drinking	35	40	36	35	33	32
#195 Might not get good job	30	31	28	31	28	30
#206 Physical development	26	31	28	27	24	17
#201 Nuclear destruction of U.S.	25	29	29	27	22	21
#212 Parents might divorce	22	30	26	22	17	17
#200 That I may die soon	21	26	24	24	17	13
#196 Sexual abuse	19	23	21	19	17	14
#210 Friends will get me in trouble	18	29	21	18	13	13
#207 Drinking by a parent	15	21	16	14	11	11
#205 Get beat up at school	12	18	16	12	9	9
#199 Physical abuse by parent	12	17	13	12	9	9
#194 That I might kill myself	11	16	12	11	9	6

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- Twenty-five percent of young adolescents worry very much or quite a bit about the possibility of nuclear destruction.
- Worry and concern about global issues like hunger and war is highest in the 5th grade and decreases with each advance in grade.
- Parents radically underestimate the extent to which young adolescents worry about destructive or harmful events and forces.
- Parents overestimate the extent to which young adolescents worry about peer relationships.

MORAL BELIEFS

- Young adolescents were asked to judge the "rightness" or "wrongness" of six actions. On the situations dealing with perpetrating a classroom disturbance, shoplifting, and racial discrimination, more than 80 percent in each of the five grades judged the action to be wrong.
- The perceived wrongness of lying to parents and drinking alcohol at age 13 decreased between the 5th and 9th grade.
- Of the six situations, the one judged least wrong had to do with a 15-year-old girl getting an abortion. This was also the only situation in which perceived wrongness increased between the 5th and 9th grade.
- On each of the six behaviors, girls were more likely to attribute wrongness than boys.

VALUES

- Out of the list of 24 values, the two most important to young adolescents in each grade between 5th and 9th are "To have a happy family life" and "To get a good job when I am older." The least important value to young adolescents is "To be good in music, art, or drama." The rank order of values for each grade is listed in Table 7.
- The two values which increase most between 5th and 9th grade are "To make my own decisions" and "To do something important with my life."
- Values which become less important between 5th and 9th grade include God, church, and concern for people and the world.
- Girls are more likely than boys to embrace values of friendship, family, and concern for people and the world.
- Boys are more likely than girls to hold Hedonistic values (e.g., "To do what I want to do, whenever I want to do it," and "To have lots of money").

Table 7:

Relationship of Values to Grade in School

VALUE	Item No.	Average: All Youth	RANK All Youth	RANK 5th	RANK 6th	RANK 7th	RANK 8th	RANK 9th
Happy family life	142	4.24	1	1	1	1	1	2
Get a good job	154	4.16	2	5	3	2	2	1
Do something important	156	4.10	3	8	5	3	3	3
Do well in school	157	4.09	4	2	2	4	5	6
Make parents proud	143	4.06	5	4	4	5	4	7
World without war	158	4.00	6	3	6	6	8	8
Friends I can count on	161	3.99	7	7	8	7	6	5
Feel good about myself	147	3.97	8	9	9	8	7	4
God at center of my life	152	3.89	9	6	7	9	9	10
Fun and good times	149	3.81	10	10	11	11	11	9
World without hunger	153	3.80	11	12	10	10	10	11
Safe neighborhood	146	3.68	12	11	12	12	13	14
Understand my feelings	150	3.56	13	15	15	13	14	13
Make own decisions	144	3.51	14	19	19	14	12	12
Be part of a church	163	3.49	15	13	13	15	17	15
Help people	145	3.48	16	14	16	16	18	16
Be good at sports	159	3.44	17	16	14	17	16	19
Look good to other kids	164	3.41	18	17	18	18	15	17
Have nice things	155	3.39	19	18	17	19	19	18
Popular at school	148	3.28	20	21	20	20	20	21
Have lots of money	151	3.23	21	20	21	21	21	20
Be different from other kids	160	2.95	22	22	22	22	22	22
Do what I want to do	162	2.85	23	24	24	23	23	23
Good in music, drama, art	141	2.79	24	23	23	24	24	24

SOCIAL ATTITUDES

- Only a minority of young adolescents admit to prejudice on the basis of race, sex, or age.
- There is a slight decline in racial prejudice between the 5th and 9th grades.
- Boys hold more racial prejudice than girls.
- Sixteen percent of boys and three percent of girls say that "Men should have more freedom than women." Twenty-two percent of boys and ten percent of girls disagree with the statement that "Women should have all the same rights as men."
- Prejudiced young adolescents tend to have prejudiced parents.
- Most young adolescents oppose increased government spending for weapons.
- Most young adolescents favor increased government efforts to combat poverty and hunger.

RELIGION

- The majority of young adolescents in this study report that religion is the most important or one of the most important influences in their lives.
- Religious centrality (the degree to which religion is regarded as important in one's life) does not change for girls between the 5th and 9th grade. For boys, it begins a downward turn after 6th grade, with a particular drop between the 8th and 9th grade.
- The majority of young adolescents in this study report that they pray, other than at meals or in worship services, "every day" or "most days." The percentages decline between the 5th and 9th grade. Boys reveal the greater decline.
- Beliefs about God and Jesus are very stable across the five grades. Eighty-six percent of all young adolescents in this study are quite sure or sure that God exists, and 87 percent affirm the central axiom of the Christian tradition--that Jesus died and was resurrected. These rates are parallel to those reported in Gallup polls on the American adult population.
- Girls are more likely than boys to be certain about God's existence and to affirm the divinity of Jesus.
- On two measures of religion--religious centrality and liberating religion--there is a marked decrease for boys between the 8th and 9th grade. Young adolescents in this study tend to experience religion more as liberating than restricting. In part, this means that young adolescents focus more on God's love than God as judge or rule-giver.

- When asked to describe how they understand the responsibilities of the religious life, the majority of young adolescents cite both vertical (to honor, obey, worship God) and horizontal (to care for other people, engage in acts of love, combat social injustice) responsibilities. Fifty-six percent believe both of these dimensions are important.

- For young adolescents, religious centrality and a liberating religious orientation (emphasis on God's love and forgiveness) are relative to positive values and behaviors. However, a restricting religious orientation (an emphasis on God as judge and rule-giver) appears to be problematic for young adolescents. Those who are high on this measure tend also to be high on anti-social behavior and alcohol use. It is also tied to racial prejudice and sexism. One possible explanation is that a restricting religion sets high behavioral standards which conflict with a young adolescent's inclination to grow in autonomy and independence. The conflict could create rebellion on the one hand, or a kind of authoritarianism which breeds prejudice on the other. Another possibility is that adults begin to use God "as a hammer" with young adolescents who engage in problem behaviors. There is evidence in the survey data that young adolescents high in a restricting religious orientation tend to experience coercive forms of discipline at home.

BEHAVIOR

Prosocial

- The young adolescent survey included six questions about how much one is inclined to help other people. One of these questions was as follows:

  Do you spend time giving help to people **outside the family** that have special needs (for example, collecting food for hungry people, or mowing lawns for people who can't do it themselves, or spending time with sick or handicapped people)? Think about the helpful things you have done **in the last month**--for which you **did not get paid,** but which you did because you wanted to be kind to someone else. About how many hours did you give help **during the last month?**

  The response options are:
  None
  1 to 2 hours
  3 to 4 hours
  5 to 10 hours
  11 hours or more

  One out of three young adolescents (34%) reported giving no help; 40 percent helped 1-2 hours, and 26 percent reported three hours or more.

- At each grade level between 5th and 9th, girls report more prosocial behavior than boys.

Anti-Social

- A majority of young adolescent boys (64%) and a significant minority of girls (32%) report that they have "hit or beat up another kid during the last 12 months."

- Sixteen percent of boys report they have been involved in six or more fights during "the last 12 months."

- In the 5th, 6th, and 7th grades, the majority report that they did not cheat on a test at school. In the 8th and 9th grades, more than 60 percent report cheating at least once "in the last 12 months." Nearly one-third of 9th graders report cheating three times or more "in the last 12 months."

- About one out of five young adolescents in each of the five grades report stealing something from a store one or more times "in the last 12 months."

Chemical Use

- Use of alcohol becomes quite common by the 8th and 9th grades. Twenty percent of 9th graders report use of marijuana once or more during "the last 12 months." Percentages by grade for six items are as follows:

	5th	6th	7th	8th	9th
Percent who used alcohol during the last twelve months (once or more)	22	25	31	42	53
Percent who used alcohol during the last twelve months (six times or more)	8	7	8	11	22
Percent who report being drunk during the last twelve months (once or more)	12	11	13	17	28
Percent who report marijuana use during the last twelve months (once or more)	12	10	10	13	20
Percent who smoked one or more cigarettes during the last twelve months	19	21	23	30	36
Percent who report attending a party where peers were drinking alcohol (once or more during the last twelve months)	11	12	18	30	47

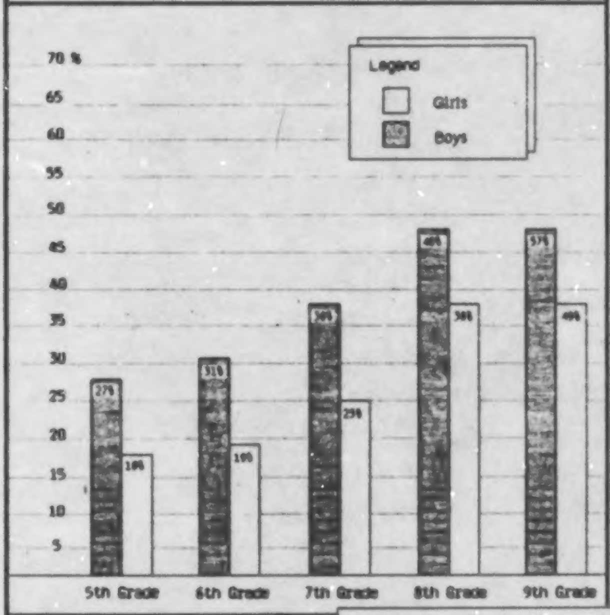
- On all six items displayed above, the percentages for boys are higher than for girls. Table 8 shows the sex difference for alcohol use (once or more).

- Young adolescents were asked: "If you have ever drunk beer, wine, or liquor, how old were you when you had your first drink? (Don't count taking a sip of someone else's drink.)"

10 or younger
11
12
13
14
15 or older
I've never had alcohol to drink.

Table 8:

Alcohol Use, "Last 12 Months"



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Youth #257 In the last 12 months, have you had beer, wine, or liquor to drink? (Do not count the times you took just a sip of someone else's drink.)

No	Yes, 6 to 9 times
Yes, 1 or 2 times	Yes, 10 to 19 times
Yes, 3 to 5 times	Yes, 20 times or more

- Twenty-seven percent of 5th graders indicated they were 10 or younger when they had their first drink, as compared with 15 percent of 8th and 9th graders who had their first drink at 10 or younger. This suggests that experimentation with alcohol by age 10 is on the increase.

III. FINDINGS: MOTHERS AND FATHERS

VALUES

- Out of a list of 16 values, both mothers and fathers rate "To have a happy family life" highest. Table 9 lists the 16 values, from most valued to least valued (each value item has a range of 1 to 5).
- The second highest value for both mothers and fathers is "To be a good parent."
- Mothers place more value than fathers on: "To have God at the center of my life," "To have a world without hunger or poverty," and "To be a good parent."
- Fathers place more value than mothers on "To be successful," and "To have lots of money."
- Compared with their parents, young adolescents place less value on "To have a happy family life,"--though happy family life is their highest priority--and more value on these six:

  To do something important with my life
  To have friends I can count on
  To have lots of fun and good times
  To have a world without hunger or poverty
  To have lots of money
  To do what I want to do, when I want to do it

  The stronger hedonistic values of youth are balanced by high value placed on "To have a world without hunger or poverty."

MORAL BELIEFS

- The young adolescent and parent surveys had five moral belief items in common. On four of these, parents are higher than their children in attributing "wrongness." The percentages for "wrong" or "very wrong" are as follows:

	Mothers	Fathers	Sons	Daughters
Shoplifting	95%	94%	87%	96%
Lying to parents	95%	95%	78%	86%
Teenage abortion	56%	53%	44%	47%
Teenage alcohol use	96%	93%	71%	80%

- The other situation had to do with residents of a white neighborhood trying to stop a black family from moving in. In this case, young adolescents were more likely than their parents to see the action as "very wrong."

Table 9:
Ranked Values by Parents

Value		Means		Percent ranked "at the top of my list"	
		Mothers	Fathers	Mothers	Fathers
#313	To have a happy family life	4.75	4.60	79%	67%
#324	To be a good parent	4.65	4.41	70	50
#325	To have wisdom	4.19	4.06	35	28
#318	To have God at the center of my life	4.18	3.76	55	39
#328	To be able to forgive others	4.09	3.82	30	20
#315	To feel good about myself	4.07	3.91	28	21
#326	To live responsibly toward others	3.94	3.78	18	13
#321	To have friends I can count on	3.67	3.56	12	9
#314	To do things which help people	3.63	3.49	11	9
#320	To do something important with my life	3.61	3.65	18	17
#319	To have a world without hunger or poverty	3.60	3.28	15	10
#323	To be successful	3.18	3.57	9	14
#316	To have lots of fun and good times	2.71	2.91	3	4
#317	To have lots of money	2.38	2.66	3	5
#322	To do whatever I want to do, when I want to	2.07	2.35	2	3
#327	To have influence and authority over others	2.01	2.28	1	1

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- Parents were also presented this situation: "Margie Smith is a 9th grader. When her parents are gone for the evening, Margie is allowed to have her friends in the house. How right or wrong are the Smiths for letting Margie have her friends over when they are not home?"

  Fifty-two percent of fatners and 54 percent of mothers judged this to be wrong.

SOCIAL ATTITUDES

- Parents describe their political orientations as follows:

	Mothers	Fathers
Very conservative	5%	6%
Conservative	32%	40%
Moderate	54%	45%
Liberal	8%	8%
Very liberal	1%	1%

  Compared with recent national polls, the parent sample is more conservative than the national adult population.

- Young adolescents (86%) are more supportive than parents (50%) of more government help for the poor and hungry.

- Boys (19%), like their fathers (14%), are more likely than girls (5%) and mothers (6%) to favor more government military spending.

- Parents are divided on the propriety of interracial dating, with 45 percent of mothers and 50 percent of fathers accepting interracial dating. About 20 percent of parents are not sure and about 30 percent disapprove.

- Parents scoring high on racial prejudice are more likely to be politically conservative and to have less education than others.

- Most parents adopt egalitarian positions on the roles of men and women.

	Mothers	Fathers
Even if they have families, women should be given opportunities equal to men to work and have careers outside the home.		
(% Agree or strongly agree)	72%	63%
Mothers and fathers should play an equal role in caring for children, even if it means taking some time away from their jobs.		
(% Agree or strongly agree)	63%	59%

	Mothers	Fathers
I think women should have all the same rights as men. (% Agree or strongly agree)	65%	72%
I think men should have more freedom than women. (% Disagree or strongly disagree)	94%	84%

- Parents tend to be slightly more traditional in sex-role expectations than their children are.

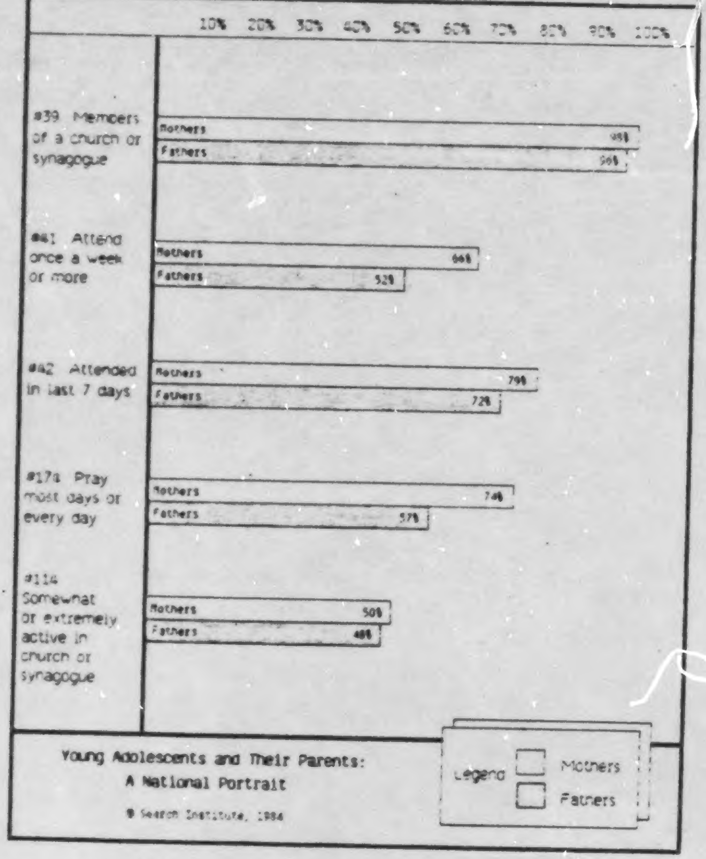
IDENTITY AND BEHAVIOR

- Eighty-eight percent of the parents say they get satisfaction from being a parent.
- Only twelve percent say, "Sometimes I wish I did not have children."
- Eighty-six percent believe they are doing a good job as a parent, but 48 percent of mothers and 30 percent of fathers think that, "I am not as good a parent as I should be."
- About 70 to 80 percent of the parents in this study can be described as having relatively high self-esteem.
- About half of the parents in the study say they do no volunteer work in the community.
- Fathers are slightly more willing to volunteer for work with youth if they have a son; mothers' willingness to volunteer is not affected by sex of child.
- About one-fourth of parents say they never use alcohol.
- Almost three-fourths of parents say they never use tobacco.
- Thirty-three percent of fathers and 16 percent of mothers report using alcohol "a couple of times a week" or more.

RELIGION

- As shown in Table 10, most parents in this study are involved in a church. Mothers tend to be more involved than fathers.
- Though institutional religious participation is the norm, religion is not commonly talked about at home. Young adolescents were asked: "How often does your family sit down and talk about God, the Bible, or other religious things?" Youth responded as follows:

Table 10:
Specific Religious Behaviors of Parents



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	5th	6th	7th	8th	9th
Percent responding "Never"	41	41	42	45	46
Percent responding "Once or twice a month"	29	30	33	33	32

- Mothers, as compared with fathers, are more likely to experience religion as comforting, challenging, and liberating. Mothers are also more certain about their beliefs than are fathers, and view religion as more important than fathers.
- Parents are considerably less likely than their children to believe that religious responsibility includes a horizontal dimension (that is, to reach out to help people in acts of love and mercy).
- Young adolescents are more likely to value the church and religion if their parents do so.

IV. FINDINGS: YOUNG ADOLESCENTS AND THEIR FAMILIES

FAMILY DYNAMICS

Quality of Family Life

- Sixty-six percent of young adolescents report that their parents' relationship is "very good" or "excellent." Twenty percent rate as "good," 10 percent as "fair," and only 4 percent as "poor."
- Sixty-one percent of young adolescents say they see their parents "hug or kiss each other" often or very often.
- Only 13 percent of young adolescents report that their parents argue or get mad at each other "often" or "very often."
- Nearly three-quarters (73%) of young adolescents report it is "quite true" or "very true" that "There is a lot of love in my family."
- Mothers and fathers were asked, "How happy would you say you are with your spouse or partner?" Responses for couples currently living together were as follows:

	Mothers	Fathers
Very unhappy	11%	14%
Somewhat unhappy	8%	6%
Somewhat happy	19%	15%
Very happy	44%	45%
Extremely happy	18%	19%

- Note above that almost 20 percent of parents express unhappiness. Thus, nearly 20 percent of the relationships could be "at risk." These figures do not include couples who are separated or divorced.
- Overall, most of the youth and parents involved in this study have positive feelings about family life. In about 15-20 percent of the families, there are signs of serious marital conflict.

Affection

- With each increase in grade from 5th to 9th, young adolescents receive less verbal and physical affection from their parents.

	5th	6th	7th	8th	9th
Daily verbal affection from mother	54%	51%	47%	40%	36%
Daily verbal affection from father	44%	41%	33%	29%	22%
Daily physical affection from mother	68%	67%	60%	54%	44%
Daily physical affection from father	50%	48%	39%	34%	26%

- Mothers tend to give more affection than fathers.
- Mothers tend to give affection equally to sons and daughters. Fathers tend to give more affection to daughters than sons.

Control Techniques

This study examined three types of control exercised by parents. An authoritarian approach is non-democratic, non-negotiable, and inflexible. The parent asserts rules, tolerates little deviation from these rules, and is firm and swift with punishment. For a democratic approach, a parent seeks to establish rules and behavioral guidelines in concert with the child. The parent seeks the child's advice and input, and then firmly explains in a rational way what the agreed-upon rules are and what the consequences for rule violations are. A permissive approach is quite casual. The parent does not take time to set rules, monitor behvior, or punish.

- The most frequently used control technique is democratic, according to both young adolescents and parents.
- Youth report that democratic control techniques from both parents decline between the 5th and 9th grade.
- Mothers use democratic control techniques more than fathers.
- Boys experience more authoritarian control than girls do.
- Both parents claim less use of authoritarian control techniques with advancing grade of child; however, youth report no changes for either parent with advancing grade.
- Permissive control is reported relatively infrequently by both parents and young adolescents.

Discipline

This study looked at how parents discipline a child when he or she violates a rule or behavioral standard. The three major kinds of discipline explored were: coercion, induction, and love withdrawal. In coercive discipline, the parent seeks to control the child by capitalizing on his or her power. The parent physically strikes the child (or threatens to do so), or yells or screams at the child, or deprives the child of something he or she wants. Love withdrawal refers to parental behaviors like pouting, expressing disappointment, avoiding the child, or giving the child the "silent treatment." Induction relies more on discussion and explanation. Unlike coercion and love withdrawal, induction is not punishment or the threat of it. Rather, it is an attempt to persuade the child, on rational grounds, why he or she should behave differently. The discussion focuses on such topics as the importance of rules, why rule violation is undesirable, how rule violations conflict with the child's concern for other people and their welfare. Induction appeals to a child's own internal resources for controlling and monitoring behavior, as opposed to coercion and love withdrawal, which function to create a fear of punishment if the violation is detected by the parent. It is said that when parents depend solely on coercion or love withdrawal, some children become clever and engage in rule violations in situations where parents will not find out. The theory about induction is that it will create internal standards in a child that he or she will use to control behavior, whether or not the parent detects the behavior.

- Coercive discipline. Three kinds of coercive discipline are listed below, with the percentages of youth who report experiencing each form when "I do something wrong."

	From Mother	From Father
Parent slaps or hits me.		
% Never	48%	52%
% Once in a while	30%	24%
% Sometimes	13%	13%
% Often or very often	9%	10%
Parent yells or shouts at me.		
% Never	11%	18%
% Once in a while	31%	30%
% Sometimes	30%	27%
% Often or very often	29%	25%
Parents make me stay in the house, and won't let me be with my friends.		
% Never	22%	28%
% Once in a while	30%	29%
% Sometimes	27%	24%
% Often or very often	20%	19%

- Love Withdrawal. About 30 percent report love withdrawal occurs "often" or "very often," "when I do something wrong." Mothers are more likely to use this technique than fathers, partly perhaps because mothers spend more time with their children than fathers do.

- Induction. Of the three types of discipline, young adolescents report more inductive techniques than either love withdrawal or coercion. About 50 percent claim that mothers use inductive reasoning processes, and about 45 percent say fathers use inductive reasoning.

- Boys report receiving more coercive punishment than girls do.

- The use of inductive techniques and coercive techniques declines between the 5th and 9th grade, and the frequency of love withdrawal stays stable across the five grades. This suggests that parents do less disciplining as the young adolescent advances in age.

Further evidence of this is the percentage of young adolescents who report they "always get punished when I disobey my parents (or parent)."

	5th	6th	7th	8th	9th
% Always get punished	17%	16%	14%	11%	11%

FAMILY STRESS

- Table 11 shows the frequency of family crises as reported by parents (responses by mothers and fathers were averaged). Twenty percent of families have been touched by unemployment, and 17 percent have experienced a serious accident.
- Table 12 presents information related to the issue of physical abuse of children. Thirteen percent of boys and 10 percent of girls worry that "One of my parents will hit me so hard that I will be badly hurt." A third of mothers and fathers report that they get angry enough at their child that they become afraid of the possibility of hurting their child. More than 30 percent of parents struck their child three or more times "in the last year."
- Boys are more likely to be the targets of parental hitting and anger than are girls, and 5th and 6th graders are more likely to be targets than older young adolescents.
- These data do not definitely describe how much abuse of children actually occurs or how severe abuse events are. Among young adolescents, a small but significant percent fear the possibility of being badly hurt, and among parents, a third report being mad enough to potentially be abusive.
- Abuse of one parent by another is reported as follows:

	Reported by Mother	Reported by Father
My partner pushed, shoved, or grabbed me.		
% Once or more in the past year	14%	13%
My partner hit, kicked, or slapped me.		
% Once or more in the past year	7%	9%
My partner beat me up.		
% Once or more in the past year	2%	2%

- Factors that accompany a report of spouse violence include the use of coercive methods of discipline, family economic stress, lower family harmony as reported by both child and parents, and alcoholism in the family.

Table 11:

Family Crises Reported by Parents

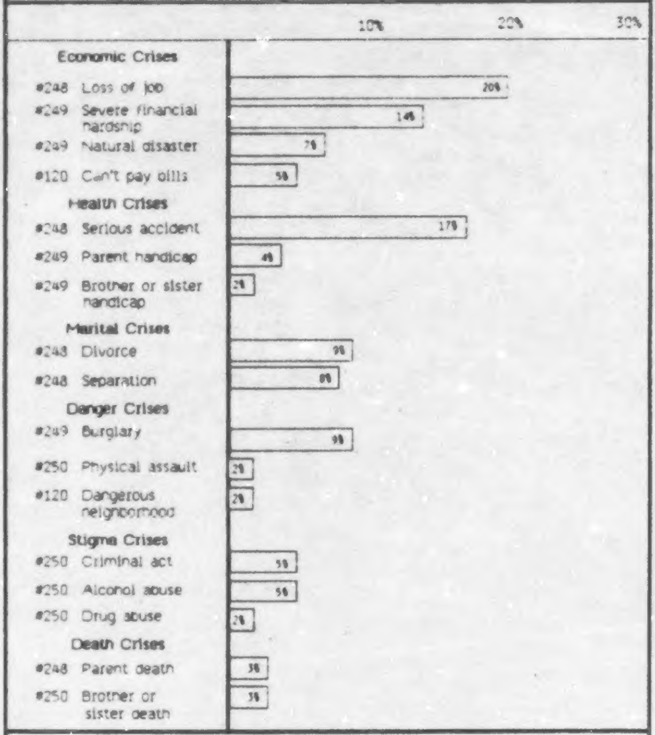

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Table 12:
Physical Abuse of Child by Parents

Youth #199 I worry that one of my parents will hit me so hard that I will be badly hurt.

Percent very much or quite a bit by grade

	5th	6th	7th	8th	9th	Total
Boys	20%	13%	15%	10%	9%	13%
Girls	15	12	12	8	6	11

Parent #106 How many times in the past year would you say you spanked, hit, slapped, or otherwise put a hand to your child?

		None	Once or twice	3–5 times	6 to 10 times	11 times or more
Mothers of	**Boys**	25%	32%	22%	12%	10%
	Girls	31	34	20	9	5
Fathers of	**Boys**	29	33	21	10	8
	Girls	41	34	16	6	4

Percent 3 or more times by grade

	5th	6th	7th	8th	9th	Total
Mothers	57%	46%	39%	31%	22%	39%
Fathers	46	40	30	26	19	32

Parent #220 How often do you get so angry at your child that you are afraid you might hurt him or her?

		Never	Once in a while	Sometimes	Often	Very often
Mothers of	**Boys**	65%	27%	6%	1.4%	0.7%
	Girls	69	24	5	1.3	0.7
Fathers of	**Boys**	61	29	7	2.8	0.5
	Girls	72	21	6	1	0.7

Percent once in a while or more frequently by grade

	5th	6th	7th	8th	9th	Total
Mothers	32%	34%	31%	31%	28%	33%
Fathers	37	36	33	31	32	33

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CHILD AND PARENT COMMUNICATION

Both young adolescents and their parents were asked a number of questions about the topics they would like to discuss more with each other.

- The percentages of young adolescents who want more discussion with parents are as follows:

Topic	Percent who want to talk more with parents
About how my parents and I get along	49%
About my ideas of what's right and wrong	47%
About what my parents expect of me	47%
About how I'm doing in school	46%
About my friends	44%
About questions I have about sex	39%
About problems my parents have	38%
About drugs and alcohol	37%

- Fifth and sixth graders typically desire more discussion than 7th-9th graders.
- The percentages of parents who would like to talk more to their young adolescent are as follows:

	Percent of Mothers	Percent of Fathers
About my love for my child	92%	87%
About God and other religious topics	87%	75%
About world events	60%	58%
About my child's questions about sex	50%	33%
About drugs and alcohol	42%	38%
About my child's view of right and wrong	43%	34%
About school	37%	29%

- On three topics, more than one-third of parents and children want more conversation with each other. These areas are sexuality, drugs and alcohol, and morality (right and wrong).

MARITAL STATUS

- The marital status of parents in this study is as follows:

	Mothers	Fathers
1. % Single and never married	1%	0%
2. % Divorced and now single	5%	1%
3. % Widowed and now single	1%	0%
4. % Separated	1%	0%
5. % Divorced and remarried	6%	5%
6. % Widowed and remarried	1%	1%
7. % Married (to original spouse)	85%	92%

- A single parent with children is much more likely to be a woman than a man (our ratio is about 8 to 1. National census figures put the ratio at 9 to 1 or 10 to 1).

- A comparison was made of three of these groups: divorced and now single, divorced and remarried (reconstituted), and married. Some important patterns emerge:

  1. Life in the single-parent home is not as negative as many stereotype it. In a sense, the single parents in this study (who are predominately women) are heroic. They work against great economic disadvantages (78% of the single parent group earn less than $20,000 per year; 30% earn less than $10,000 per year; only about 20% of the reconstituted and married group report less than $20,000 in family income).

  2. Single-parent families are equal to or almost equal to the married families in nurturance, affection, child's self-esteem, and child's school achievement. Single-parent families are not without problems. Youth in this kind of family tend, for example, to engage in slightly more aggression and slightly more alcohol use than youth in the married parent group. But the differences are rarely pronounced. On balance, the young adolescents in single-parent settings look quite healthy.

  3. The signs of problems and stress are more visible in the reconstituted family than in the single-parent families. For example, young adolescents in a reconstituted family setting, compared with the other two settings, report the most alcohol and drug use, the most worry about parental physical abuse, the most "peer pressure to deviance," and the least trusting and most authoritarian parents. To some extent, it may be that youth in the reconstituted context experience a good deal of stress, including the stresses of adapting to a new parent and new brothers and sisters.

- Overall, on most variables the three family types do not differ appreciably from each other. We conclude that the single-parent family is functioning better than many people think. Remarriage is not a fail-safe antidote. Remarriage sometimes places young adolescents in a difficult position. It is likely that remarriage is beneficial to some youth but not to all youth. Further research is needed to sort out the factors which help make remarriage work to a child's advantage.

V. FINDINGS: DESIRE FOR NEW PROGRAMS

- Young adolescents were given a list of ten program areas and were asked to express "How much you would be interested if this kind of help were offered by a club, school, church, or community group?" The percentages of youth who indicated much interest or some interest are given in Table 13.
- Parents were given a list of seven program areas. Table 14 shows the percentages of mothers and fathers who report they are very interested or quite interested in these programs.
- These percentages suggest a number of program areas that capture the interest of most young adolescents, mothers, and fathers.

Table 13:
Young Adolescents' Interest In New Programs

Topic	Percent much interest	Percent much interest plus some interest
#285 Learning how to make friends and be a friend	61%	93%
#286 Finding out what is special about me	51	92
#289 Figuring out what it means to be a Christian	51	88
#288 Learning about what is right and wrong	50	91
#292 Talking with other kids about things that are really important	41	91
#293 Learning how to talk better with adults	40	90
#291 Learning how to deal with drugs and alcohol	31	65
#284 Finding out how to do something good for others	31	94
#287 Understanding sex better	30	79
#290 Figuring out what it means to be Jewish	10	38

Young Adolescents and Their Parents:
A National Portrait

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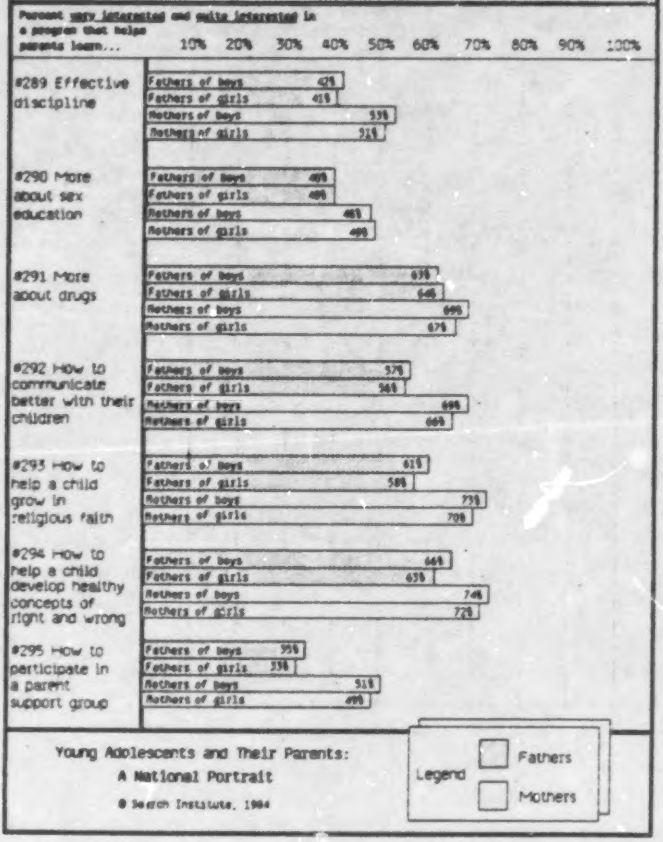
Based on survey questions #284-#293. Percentages based on total young adolescent sample.

Table 14:
Parents' Interest in New Programs



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VI. THEMES AND RECOMMENDATIONS

There are a number of themes present in this Summary of Findings and in the larger Project Report. Some of the more salient ones are these:

Good News About Families

In recent years, many have claimed that American families are in trouble. According to the mass media, marriages are disintegrating in epidemic numbers, parents and children are spending little time with each other, children are raised by their peers rather than their parents, and many children are victimized by rejecting and/or abusing parents. The picture that emerges in this study is quite different. This may be due, in part, to the selective nature of the sample (e.g., primarily church-related families). Nonetheless, what we see is much more positive than the common stereotype of American family life. On the whole, we see parents who are genuinely struggling to be good parents, young adolescents who feel relatively good about their parent or parents, parent-child relationships which are much more affectionate and supportive than rejecting or hostile, parents and children who like to be with each other, and families relatively immune to major crises such as chemical dependency, abuse, or violence.

We do not mean to imply that youth and families are functioning at optimal levels. Indeed, there are stresses and problems in most families. However, we find that the needs, despairs, and longings of youth and parents tend to be more subtle, less catastrophic, and perhaps more benign than we have been led to believe. The message here is this: the youth and parents we are trying to serve, whether it be through secular youth organizations or churches, are stronger and healthier than is commonly depicted. This provides, on the average, a positive setting, a strong foundation, for helping youth and families prosper and grow.

Good News About Young Adolescents

Just as the family is stronger than often depicted, we find that the young adolescent has more redeeming qualities than many are willing to admit. At first glance what is seen is the chaos of this age period, including the young adolescent's proclivity to inconsistency--to want to be treated as an adult but acting the child. And granted, there may be no greater challenge than being put in charge, alone, of 20 or 30 7th to 9th graders. But in this chaos there are real signs of growth, of creative adaptation to a myriad of internal and external changes. In some ways, it is a wonder youth survive this simultaneous onslaught of biological, emotional, self-concept, and cognitive changes. But when we look deeper, we see kids moving forward. When we take a single snapshot of this fast-moving age period, we see the vast majority doing constructive things such as building friendship skills, growing in empathy, valuing parents and family, struggling with issues of freedom and independence, opposing racial discrimination, caring about the hungry and the poor, and contemplating the future. There are problems to be sure. But the theme of constructive adaptation and growth is more descriptive of the majority.

Variability

There is extreme variability in how young adolescents develop. There is no such thing, for example, as a typical 8th grader. The timing of a number of changes---biological, cognitive, emotional, social--varies widely. Even the sequencing of these changes differs from individual to individual.

Sex Differences

Differences between boys and girls are commonplace in this study. Girls, for example, are considerably ahead of boys in pubertal development. And in many other areas, girls also seem to outshine boys. This is true for interest in school, the development of social competencies, educational aspirations, and concern about other people. Boys, on the other hand, tend to have a monopoly on various forms of aggression, violations of social norms, and chemical use. Overall, one gets the impression that girls "graduate" out of early adolescence with greater maturity than boys do.

Importance of Parents and Peers

There is no doubt that friends and peers grow in importance between the 5th and 9th grades. Young adolescents find each other, cling to each other, and are traumatized when they can't be with their friends. It is relatively common to come to two erroneous conclusions about this. One is to characterize peer influence as a threat to healthy development. Another is to assume that as youth move toward their peers, they abandon their parents. By and large, we find peer relationships to be a crucial process for healthy development. It is in the crucible of peer relationships that children and adolescents teach each other a great deal about values, morality, sex-roles, the control of aggression, and a host of other phenomena. What matters is the crowd one hangs around with. Peers can press each other toward growth and responsibility, or toward deviance. We find that there is more press toward the former than the latter. As to the second conclusion, we find that young adolescents do become, or want to be, independent of their parents. Though it is true that peers become more influential between the 5th and 9th grade, and that parents become less so, we also find that in no grade does the influence of peers outweigh the influence of parents. When asked where they would turn for help and guidance on a variety of topics, in every case, young adolescents seek out parents more than their peers. And as shown in the section on values, "To make my parents proud of me" is valued more than maintaining friendships.

Family Dynamics Matter

What young adolescents become and how they behave are strongly tied to life at home. We find family closeness, parental nurturance, parental affection, inductive discipline, and democratic control to be closely associated with both the inhibition of anti-social behaviors and chemical use, and the promotion of prosocial, responsible behavior. On the other hand, we find authoritarian control, coercive punishment, and less nurturance linked to a series of less desirable outcomes.

Church and Religion

Even though the samples in this study tend to value church and religion, there is enough variability in the samples to compare those who have different levels of commitment in these two areas. There is strong evidence that youth who value the church and are involved in it tend to engage in less anti-social behavior and have more concern for people and the world than those who take a less positive posture toward the church. The role of religious beliefs is a bit more complicated. When religious faith is experienced as liberating, positive consequences seem to occur. However, when religious beliefs are on the restricting side (e.g., God as judge and rule-giver), there are signs that this form of religion is counterproductive. Many more young adolescents experience faith as liberating than restricting.

The "Hurried Child"

Although there exist little objective data on which to prove it to the skeptic, it appears that 5th to 9th grade youth are now dealing with issues which previous generations confronted at an older age. The data presented on sexuality, worries and concerns, and chemical use show that many current young adolescents are thinking about or experimenting with areas many adults wish could wait until at least high school. What is particularly noteworthy are the percentages of 5th and 6th graders who are grappling with issues of sexuality and chemical substances and also have worries and concerns about issues such as sexual abuse, world hunger, and nuclear destruction. This raises serious questions about how well equipped young adolescents are to confront these areas.

Trouble Spots

We have testified in the previous paragraphs that there are plenty of positive features in this study worth celebrating. But there are other features that deserve serious thought and reflection. These include:

- The nearly 20 percent who experiment with sexual intercourse, as reported by 7th, 8th, and 9th grade young adolescents.
- The worry about sexual and physical abuse that a significant number of young adolescents express.
- The involvement some young adolescents have with alcohol and marijuana.
- The worry about nuclear destruction that young adolescents express.
- The tension experienced by some families, including family violence and marital conflict.
- The relatively commonplace occurrence of some forms of aggression among young adolescents.
- The social alienation experienced by some youth, particularly boys.

Social Networks

There are indications that much of the anti-social behavior of youth is associated with turmoil, stress, frustration, or deprivation in other areas of their lives, whether those areas be family, school, or non-acceptance by peers. Where youth are found in a strong supportive network of family, church, school, and community there is both less pressure and less opportunity to engage in behaviors contrary to social norms and expectations.

Parents as Models

These data provide a variety of instances in which parents' patterns of beliefs and value preferences are found also among their children. Parents are significant role models for their youth, for better or worse, and these linkages can be traced.

What directions should program agencies take to help young adolescents and their families grow and prosper? This is the "bottom line" question, and the answers will evolve as groups of concerned adults and youth gather to discuss and interpret the findings. The process is already underway in each of the 13 agencies which cooperated in this project.

Additional directions for programming will emerge from the invitational conference, Listening to Early Adolescents and their Parents (LEAP '84), to be held in Nashville, February 26-29, 1984.

The list of 26 recommendations presented here represents initial judgments by the project staff at Search Institute. These recommendations are not intended to be exhaustive or definitive, but rather should be seen as grist for discussion and debate. We state these in terms of directions program agencies should take, knowing that some organizations are already doing effective work in some of the highlighted areas.

*****

Youth Program Processes

1. Programs should take seriously young adolescents' growing need for autonomy and self-determination. Programs should provide young adolescents with experience in making decisions, setting rules, and shaping program content, while at the same time making the limits of this freedom explicit.
2. Youth group leaders should become aware of the significant sex differences that occur during early adolescence. Though there are boy/girl commonalities, there are some significant differences in values, worries, needs, and interests which need to be known and addressed.
3. Young adolescents experience a certain degree of turmoil in self-concept, based in part on changing physical characteristics and changes in adults' expectations. Youth program leaders should seek to: (a) help young adolescents reflect on these changes, (b) provide positive feedback, and (c) provide opportunities in which young adolescents can experience a sense of mastery and competence.

Program Content for Young Adolescents

4. Programs should be offered which help young adolescents explore and discuss vocation and career. "To get a good job when I am older" is one of the top values of young adolescents.

5. The highest concern for global issues like poverty and peace is found among 5th and 6th graders. With advancing grade, this concern decreases. It may be that 5th and 6th grade youth are given too little encouragement and/or too little opportunity to express these concerns through concrete action. Youth programs should take these concerns seriously by helping young adolescents take constructive action and helping young adolescents reflect on these experiences.

6. Programs should be offered on chemical awareness. A signficant percentage of young adolescents, including 5th and 6th graders, are experimenting with alcohol and other substances. Even if local public schools provide such programs, it is important to reinforce this area and tackle it from several vantage points.

7. Most young adolescents report that they do not have good conversations with their parents about sexuality. It is important that young adolescents have opportunity to discuss sexuality in a value context. Programs should be offered to provide this value-based approach. Given some of the findings, 5th grade is not too early to begin.

8. About 20 percent of young adolescents worry about the potential of sexual abuse. Programs should be developed which help young adolescents understand this problem and develop skills for avoiding possible abuse situations.

Table 13 of this report summarizes topics that young adolescents want programs to address. To meet these needs, the following three program areas should be covered:

9. Programs should be offered which help young adolescents develop friendship-making and friendship maintaining skills.

10. Programs should be offered which help young adolescents struggle with moral judgment questions.

11. Programs should be offered which help youth develop skills for communicating with adults.

Target Age for Young Adolescent Programs

12. Youth-serving organizations such as 4-H, Boy Scouts, Girl Scouts, and Camp Fire provide quality programming for 5th and 6th grade youth. Many local churches do not. National church bodies should begin to provide direction and resources for this age group. Fifth and 6th graders are beginning to

exhibit needs, interests and risks not unlike those of junior high age youth. As much as we would like to believe that 5th and 6th graders are insulated from various facets of youth and adult culture, our data suggest otherwise. Fifth and 6th graders are particularly impressionable, prone to worry, and lacking in skills to process and understand some of the things they see and experience.

Programs for Parents

13. Programs should be offered to help parents develop parenting skills, including methods of effective discipline and control.

14. In church-related institutions, it is significant that only a minority of church-connected families discuss religion at home with their children. Programs should be developed which help parents promote the faith development of their children.

15. A significant percentage of parents of young adolescents are interested in participating in a parents' support group. Local program agencies should determine the level of interest in this and provide, if the interest warrants it, a mechanism for initiating this kind of program.

Table 14 shows other program areas that would capture the interest of parents. Recommendations 15-17 focus on three needs of parents.

16. Programs should be developed which help parents discuss sexuality with their children.

17. Programs should be developed which help parents stimulate moral development in their children.

18. Programs should be developed which help parents discuss alcohol and drugs with their children.

Programs for Young Adolescents and Parents Together

There are several areas where young adolescents and parents desire more communication with each other. Programs should be developed which help families explore these topics. Families may need a certain amount of structure, supervision, and permission to begin these conversations. With a capable and trained facilitator, families could make important progress.

19. Programs should be developed which help parents and young adolescents discuss sexuality.

20. Programs should be developed which help parents and young adolescents express both their joys and disappointments about each other.

21. Programs should be developed which help parents and young adolescents discuss chemical use.

22. Programs should be developed which help parents and young adolescents discuss issues of moral judgment.

General Program Development Procedures

As national youth-serving agencies begin to move from interpreting this information to resource development, three strategies are recommended:

23. Program developers should make contact with those organizations which have developed, or know of, programs targeted for the young adolescent. One important resource is the Center for Early Adolescence, Suite 223, Carr Mill Mall, Carsboro, North Carolina 27510. *The Journal of Early Adolescence* occasionally provides reports on or evaluations of programs tailored to the young adolescent.

24. Program developers in national youth-serving agencies should develop mechanisms and strategies for working collaboratively on the development of new programs and resources.

[illegible] Local youth-serving agencies should be encouraged to work collaboratively with other community resources and agencies in addressing the needs of young adolescents and their parents.

National Communication

26. The 13 cooperating agencies, and others who serve a similar clientele, should disseminate the findings of this report to their national constituencies, with a focus on affirming the good features and qualities of family life pinpointed in this study.

NOTES

1. Special thanks are extended to five Search Institute staff members who assisted in the preparation of this Summary of Findings: Elizabeth Kurak, Bonnie Tracy, Carolyn Eklin, Joe Erickson, and Michael Donahue.

2. Kagan, J. (1972). Introduction. In Kagan, J. and Coles, R. (Eds.) *12 to 16: Early adolescence*. New York: North, p. vii.

3. Princeton Religious Research Center (1982). *Religion in America*, p. 22.

4. *Ibid*, p. 41.

5. National figures are based on 1980 United States census data.

6. The states in these four census regions are as follows:

   NORTHEAST: Connecticut, Massachusetts, Maine, New Hampshire, Rhode Island, Vermont, New Jersey, New York, Pennsylvania

   SOUTH: District of Columbia, Delaware, Florida, Georgia, Virginia, West Virginia, South Carolina, North Carolina, Maryland, Alabama, Kentucky, Mississippi, Tennessee, Arkansas, Louisiana, Oklahoma, Texas

   NORTH CENTRAL: Illinois, Indiana, Michigan, Ohio, Wisconsin, Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota

   WEST: Arizona, Colorado, Idaho, Nevada, New Mexico, Montana, Utah, Wyoming, Alaska, California, Hawaii, Oregon, Washington

7. Young adolescent family income data is from mothers' survey.

8. National figures based on census figures for 10-14 year olds.

9. National figures sum to 94 percent. The Census Bureau reports the other 6 percent as "other urban" and does not indicate how these are distributed by size.

10. Young adolescent data provided by mothers. A mother was designated in the labor force if she reported 11 hours or more per week of a "paid job."

11. National figures based on all women and all men over age 25. It is likely that actual percentages of parents in the 30-44 age range are higher.

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Sexuality

- By the 9th grade, 72 percent of girls have gone "almost through" or "completely through" pubertal development, according to the mothers in the survey. Only 36 percent of 9th grade boys have proceeded "almost through" or "completely through" puberty.
- The frequency of "thinking about sex" rises dramatically through the grades, with a greater increase reported by boys. This finding is shown in Table 4.
- Thirty-nine percent of 5th graders report "being in love." The percentage rises to 51 percent by 9th grade. This finding is shown in Table 5.
- In the 9th grade, 61 percent of girls are attitudinally opposed to premarital intercourse. However, only 36 percent of 9th grade boys hold the same attitude.
- Young adolescents responded to this question: "Have you ever had sexual intercourse ("gone all the way" or "made love")?" The percentages who report engaging in intercourse one or more times are:

5th	6th	7th	8th	9th
12%	16%	15%	17%	20%

  The 5th and 6th grade data may be suspect, reflecting in part uncertainty about the meaning of the term "sexual intercourse." It is safe to assume that 8th and 9th graders know what is being asked. For these two grades, nearly one in five report experience with sexual intercourse.
- There is a major boy/girl difference on the intercourse item. The percentages of boys and girls who claim to have engaged in intercourse one or more times are as follows:

	7th	8th	9th
BOYS	22%	26%	28%
GIRLS	9%	9%	13%

- Only about one-third of young adolescents report that they have had "good talks with my parents about sex."

WORRIES AND CONCERNS

- From a list of potential sources of worry, young adolescents worry most often about these three: "About how I'm doing in school," "About my looks," and "About how my friends treat me." The percentages for all 20 questions are shown in Table 6.
- Worry about victimization (or physical or sexual abuse) is highest among 5th graders. These kinds of worries decrease as age increases. Nearly one out of every four 5th graders worries about the possibility of sexual abuse.

Senator Denton. Thank you very much, Dr. Strommen, and I want to acknowledge our gratitude to the White Foundation for making your visit to this hearing possible, and state that I find your study to be fascinating, informative, and apparently, encouraging. It illustrates something that I believe is quite remarkable; the overwhelming number of the adolescents sampled want to learn more about what is right and wrong.

Now, I have found this to be true in my own family. Although the kids will act rebellious, and sometimes "tune-out their hearing aids" when the parent starts to talk, one of their deepest curiosities and desires is what you said your sample indicated. They do want to know. They do want to know from their parents about what is right and wrong, and according to you, more about how to talk better with adults, more about how to deal with drugs and alcohol, and more about sexuality.

Likewise, the majority of the parents want to know how to communicate better with their children on each of these very same subjects.

So it does seem that we can improve things by facilitating communications.

It seems to me that parents and children want more to do with one another than is generally believed, and I want to make sure that that is your impression from your work, that children want to hear more from their parents on those subjects than is generally recognized.

Dr. Strommen. Yes; that is correct. In fact, we have a number of measures. One has to do with the internalization, a type of discipline that we call an inductive discipline, where the parent, instead of imposing moral standards on the child, rather, in a quiet and rational way, gives reasons for certain positions. The parent explains how behaviors will affect the well-being of the child, how it affects other people, and hoping in this way both to develop a concern for others and insight as to what represents the best approach. And we find that with this kind of inductive discipline, there is an internalization of moral beliefs. For these young people, there is a greater likelihood of their not becoming involved in certain negative behaviors.

I should also comment here that Dolores Curran, in her book, "Traits of a Healthy Family," surveyed 551 professionals who work with families. Of the 56 possible characteristics she gave them, they rated seventh from the top the trait that says, "Teaches a sense of right and wrong". This family trait indeed is seen increasingly as an important element.

Senator Denton. Much of your study deals with fostering better communication between parent and child in terms of programs. Which agency do you see as best able to provide those sorts of efforts?

Dr. Strommen. As far as those in our sample are concerned, the trust relationship is with religious institutions and youth-serving organizations. Therefore, they will turn to them first for help and have done so in the past. We have asked them to evaluate how helpful they found the programs that were offered through these institutions. A group of around 38 to 40 percent indicated that they either found them very helpful or quite helpful, to outrank any other group mentioned in the study. Community agencies, schools, and the like, tended to taper off in terms of the percent who go to them and use their programs.

I personally feel that the population that I am representing at this point needs to become more aware of the many opportunities that are present in a community for service and help from other institutions.

Senator **Denton**. Could you elaborate on the point about the successful outcomes, in terms of behavioral patterns of children later in life and while they are children, as it derives from the passage of values on from the parents to them—if you wish to add anything to what you have already said.

Dr. **Strommen**. Well, this happens to be a basic stance that we have adopted as a result of a number of studies involving people of all ages. We have been able to establish the fact that the best predictor of what people will say or do is to know what they value and believe. We have been able to establish this through a number of studies, and most recently, the study which we did of the people in the Senate and the House, with respect to voting behavior.

With respect to the passage of values, we find that values are being communicated from the parent constantly, so that the umbilical cord is really never cut. Young people tend to adopt the same values and beliefs of the parents. This points out the need for parents to be given assistance in clarifying where they wish to stand with respect to various standards.

We did ask the parents to indicate their attitude toward traditional types of adolescent behaviors that are either deemed right or wrong. The vast majority, 9 out of 10, concurred in the traditional moral beliefs that have been a part of our tradition.

Senator **Denton**. As a result of your studies, then, would you view with alarm, concern, categorically condemn, or approve, of Government-funded agencies who take upon themselves the passing on of advice in such value-related areas as drug abuse, alcohol abuse, unmarried sexual intercourse, contraceptives with health implications other than psychological and moral—programs which the Government funds and deliberately excludes the parent, and will bang on the table as a witness here and say, "We demand exclusive confidentiality," in their literature and in their movies, which frequently remind the child that the parent is anachronistic, is not to be listened to on these subjects?

I have to deal with this. I do not have your knowledge in terms of the surveys which you have undertaken, nor your expertise in your field.

How would you state your view of sex programs?

Dr. **Strommen**. I feel that there are certain values that are in the interest of public well-being, and that these are values to be encouraged in any Government-sponsored area. I take, for instance, the public school system. I think the public school needs to be, and does, promote such values as honesty, fairness, respect for people, ability to be accepting of people of all races, creeds, and the like, and these are the kinds of values that, it seems to me, are necessary for the health of a country and of a nation.

I am not in favor of the imposition of values upon people or the imposition of a certain point of view, but rather, to make available to people the discussion, the rights, the merits, of the various positions that might be presented.

With respect to the area of sexual activity and alcoholism, that represents one of the big areas of concern. We are dealing here with an area of health, an area that has to do with the future well-being of young people. And it would seem very odd that there should not be a responsible approach to young people that promotes restraint in this field. To attempt a value-free approach in this area, in my opinion, is only to give a tacit impression of adult approval. But to present some activities as absolutely harmful would be in line with the Government's warning about the use of tobacco, that over time, this can have negative health effects.

Senator **Denton**. Sir, my question dealt specifically not with values, but with the exclusion of parents from Government-funded agencies which do so—consciously, deliberately, and explicitly—exclude the parent from being involved in their version of passing on values which may or may not conform to what you think would promote well-being.

Dr. **Strommen**. Mr. Chairman, I feel that the parents should be involved first and foremost. This is their area of prerogative.

Senator **Denton**. Could you elaborate further on the reasons for the difference between single-parent families and divorced and remarried families?

You hit me kind of on the head. My parents were divorced when I was in the seventh grade. I know that I am far from an ideal person, and I would be a lot better had they remained together. But my mother did raise me, and did maintain an extremely close relationship with the support system of her particular church and mine, and also the school system in which I was involved was of a relatively small student-to-teacher ratio, and did have the emphasis on morality. Maybe that is why I did not end up in jail at 15, instead of 40, when the North Vietnamese got me.

But would you care to elaborate on that?

Dr. **Strommen**. There are a number of studies, of course, in this field. There are single parent families where the children have been raised successfully. The parent, usually the mother, has been able, to be both father and mother. The majority of single parent homes however indicate stress and pressures that result in more negative behaviors among their children than typifies intact families.

The most classic study of this was just published about 2 months ago by Guidibaldi, from Kent State. In the comparisons made, the point of impact for children in fifth grade, and particularly the boys, shows itself in an escalating hostility between the boy and the mother. It also shows itself in lower academic achievement, difficulty in relationship with children in the school, et cetera.

However, where the mother or the father have been able to maintain contact with the relatives and friends of the other spouse, have been able to have grandparents come over to the home, have been able to maintain some of their support systems, this negative contrast is mitigated to where few of these negative behaviors appear.

Senator **Denton**. Does there appear to be any greater understanding among the bulk of the teenagers, the majority, that there is greater hardship on the part of the single parent who is raising them, and is there any apparent consideration or empathy shown by the adolescent in that case?

Dr. **STROMMEN**. Yes. I made a comparison on, I suppose, hundreds of variables between the single parent and the mothers of intact families. What happens with divorce is that the mother usually has to move to more modest housing and to another community. It means going into full-time work. Usually the income for the mother drops precipitously. One finds greater tension in the home, greater difficulty with discipline, and the greater likelihood of using severe punishment.

Single parenthood represents greater responsibility, greater difficulty, and greater pressure.

Senator **DENTON**. Well, it is certainly a difficult task for a single parent—and most are mothers. Do you have any particular ideas—I know this is rather beyond the scope of your survey—by which Government policy or private initiative could help relieve some of that difficulty?

Dr. **STROMMEN**. Yes. I think that either Government or private initiatives ought to move into the area of providing training for parents in parenting. We find that parents do not know what are the best procedures by which to handle their kids. They tend to parent as they have been parented. And training in this field would make a vast difference, and when offered, is much appreciated.

Senator **DENTON**. Especially, I would think, if I may interject, in the case of a parent who has been parented badly; that parent, be it a female parent, knows nothing other than that, although she may have, I suppose, some subconscious desire to compensate with her own children in an individual case, for that which she received as poor parenting, but she could not have as much knowledge of it because she did not experience it—is that the kind of thing you are talking about—and in this case, the training would be more important.

Dr. **STROMMEN**. Yes. From the population I represent here this morning, one-fourth of these parents will take an authoritarian, moralistic, harsh approach, and one-fourth, a permissive, one where the children can do whatever they choose. That represents half our population. For these children, it is likely they will to parent in the same way.

We, for instance, have developed a program that has been tested out and found extremely useful. Parents appreciate being trained in how to discuss matters of sexuality with their children; the words that they might use, how to speak in a natural and helpful way. And this kind of training can be provided both by Government or by the private sector. It does not have to have any value or religious overtones, except the values of restraint, the values of respect, value of kindness, of caring. Where this has been introduced, it has been extremely appreciated.

Senator **DENTON**. So, granting that there is a communications problem of that subject, and that it can be somewhat ameliorated by parent training, going beyond that, when there is sex counseling which excludes the parent, it would be better were the parent to be permitted into the problem at least at the point where the young girl is being afforded, say, a course of birth control pills at age 12 or 13; even though the parent may have been clumsy before, it would seem to me—and this is the thrust behind my own rationale on this—that that parent deserves another try at that point, because it is the desperation point, the point of decision on the part of her child, which will involve the parents having to pay, perhaps, for the raising of the child of a child, aside from the trauma otherwise unmentioned right now that occurs.

Would you agree with that?

Dr. STROMMEN. Yes. I would say that it would be a time of crisis in the life of the family and would provide a splendid opportunity for meaningful conversations between the parent and the adolescent that could have an excellent outcome.

Senator DENTON. Thank you very much for your testimony, Dr. Strommen. It has been very informative and valuable.

Dr. STROMMEN. Thank you.

Senator DENTON. There was to have been a second, single-person panel. Mr. George Gallup, of the Gallup Poll, was taken ill, and we wish him a speedy recovery.

Mr. Gallup has asked that we insert for the record the results of several Gallup polls relevant to today's hearing. These polls were conducted in recent years, and they were referred to by me in my opening statement as contrary to the guess, the estimate, that is placed upon public opinion on some of these subjects.

These data were extracted from a survey in 1980 for the White House Conference on the Family by the Gallup Poll, the November 1982 survey on alcoholism, and the testimony before the Subcommittee on Family and Human Services on March 22, 1983.

First, on the subject of importance of families during crises, in a poll, the families cited the interaction between family members as one of the most effective ways to combat threats to family life. On the subject of alcohol and drug abuse problems, 81 percent of the public view alcohol abuse as a major national problem.

Another item on a personal level, the report shows that 33 percent of the public have experienced family problems related to alcohol abuse; third, the percentage increases as younger sample populations are polled. Thus, young persons are more apt to notice family problems related to alcohol abuse than older persons.

Fourth, in addition, persons who do not have a close relationship with their parents are more likely to have low self-esteem. Persons with low self-esteem are more likely to develop problems with alcohol and drug abuse.

Next, parents cite alcohol and drug abuse as the major problem confronting youth.

Next, 6 in 10 respondents felt that alcohol and drug abuse are among the biggest threat to family life.

And finally, on the subject of alcohol and drug abuse problem, the acceptance of marijuana usage has declined from 20 percent to 13 percent among young adults since the last survey.

On the subject of attitudes on sexuality, a minority of Americans, one in four, agree that more acceptance of sexual freedom is needed.

Next, young people tend to favor sexual freedom more than adults, but they are as traditional as adults on the subject of extramarital sex.

Third, the majority of Americans believe family life is harmed by television's overemphasis on sex.

Next, 8 in 10 adults believe that sex education with parental consent is important. I will repeat: Eight in 10 adults believe that sex education with parental consent is important.

Next, 86 percent see a need for instruction in marriage and family life.

And next, at least 20 percent of Americans of all ages believe teenage promiscuity to be a major threat to family life.

This is a very relevant poll. It is a national poll. In a nationwide survey 1,509 individuals conducted between April 15, 1983 by Gallup Poll, Inc., and that is right in the middle of when we were being told what was public opinion on this subject. There is a distinct divergence between that which was simply stated as public opinion and that which Gallup found to be public opinion.

The question is, Would you favor or oppose a regulation that would require federally funded family planning clinics to notify parents when the clinic provides prescription birth control drugs and devices, such as the pill, to female children under the age of 18?

Without respect to age, the national opinion was 54 percent in favor of that regulation, and 40 percent opposed. An overwhelmingly opposite impression has been given in the national media.

Under age 30, only 45 percent favor, and 49 percent oppose such a regulation. Ages 18 to 24, 46 percent favor and 52 percent oppose; 25 to 29, 45 percent and 45 percent, equal, with 10 percent saying they did not know. In the age groups 30 to 49, those which are old enough to have teenage children, those favoring, 55 percent; opposing, 38 percent. Over 50, definitely old enough to have, and probably having had several teenage children, 60 percent favor such a regulation; 33 percent oppose. In the particular age group 50 to 64, it is 57 percent favoring, 39 percent opposed. And over 65, 65 percent favoring and 25 percent opposed.

I will ask that the Gallup Poll information just read be included in the record without objection.

[The following was received for the record:]

GALLUP POLLS

Information extracted from:

1. Survey in 1980 for White House Conference on Families
2. November 1982 Survey on Alcoholism
3. Testimony before the Subcommittee on Family and Human Services on March 22, 1983

Importance of Families During Crises:

- Families cited the interaction between family members as one of the most effective ways to combat threats to family life.

Alcohol and Drug Abuse Problems:

- 81 percent of the public view alcohol abuse as a major national problem.
- On a personal level, the report shows that 33 percent of the public have experienced family problems related to alcohol abuse.
- The percentage increases as younger sample populations are polled. Thus, young persons are more apt to notice family problems related to alcohol abuse than older persons.
- In addition, persons who do not have a close relationship with their parents are more likely to have low self-esteem; persons with low self-esteem are more likely to develop problems with alcohol and drug abuse.
- Parents cite alcohol and drug abuse as the major problem confronting youth.
- Six in ten respondents felt that alcohol and drug abuse are among the biggest threats to family life.
- The acceptance of marijuana usage has declined from 20 percent to 13 percent among young adults since the last survey.

Attitudes on Sexuality

- A minority of Americans (1 in 4) agree that more acceptance of sexual freedom is needed.
- Young people tend to favor sexual freedom more than adults, but they are as traditional as adults on the subject of extramarital sex.
- The majority of Americans believe family life is harmed by television's overemphasis on sex.
- Eight in ten adults believe that sex education, with parental consent, is important.
- Eighty-six percent see a need for instruction in marriage and family life.
- At least 20 percent of Americans of all ages believe teenage promiscuity to be a major threat to family life.

Parental Involvement:

The following was asked of 1,509 individuals in a nationwide survey conducted between April 15-19, 1983 by Gallup Poll, Inc.:

> Would you favor or oppose a regulation that would require federally funded family planning clinics to notify parents when the clinic provides prescription birth control drugs and devices, such as the pill, to female children under the age of 18?

	FAVOR	OPPOSE	DON'T KNOW
National	54	40	6
Under 30	45	49	6
18-24	46	52	2
25-29	45	45	10
30-49	55	38	7
Over 50	60	33	7
50-64	57	39	4
Over 65	65	25	10
Education:			
College	45	52	3
High School	56	37	7
Grade School	65	27	8

Senator DENTON. Our next two witnesses are Dr. Stephen Van Cleave, with TOUCH Drug Foundation, and Mrs. Joyce Nalepka, who is with the National Federation of Parents for Drug-free Youth.

I will ask Mrs. Nalepka to give her opening statement, first.

STATEMENT OF JOYCE NALEPKA, SENIOR VICE PRESIDENT, NATIONAL FEDERATION OF PARENTS FOR DRUG-FREE YOUTH, SILVER SPRING, MD, AND DR. STEPHEN VAN CLEAVE, MEDICAL DIRECTOR, TOUCH, SAN ANTONIO, TX

Mrs. NALEPKA. Thank you, and good morning, Senator Denton. I am senior vice president of the National Federation of Parents for Drug-Free Youth, and one of its founding members.

I appreciate the opportunity to testify before you, and while the focus of your hearings, "Parental Involvement with Their Adolescents in Crisis," will be far-reaching, I will be addressing primarily the issue of adolescent drug use.

However, the experience we have gained in this area clearly indicates that many other adolescent problems stem from drug and alcohol use by children. For instance, it has been estimated by teens in treatment that 70 to 80 percent of teenage girls they knew were under the influence of drugs or alcohol at the time of first sex. Teenagers commonly tell us they have frequently tried suicide or thought of trying suicide while they were using drugs. Unfortunately, 5,000 children succeed at suicide annually, and another 50,000 try. Adolescent crime is linked clearly and closely to drug use.

The National Federation of Parents was founded officially in May 1980, opened their offices in February 1981, with the sharply focused aim of educating primarily parents, but including all members of the community, using a nonblaming approach for the prevention of adolescent drug and alcohol use.

The core of the National Federation is the parent community peer group or task force, which first becomes educated on the medical and scientific effects of drug use and then works to network the entire community into a safety net for children and teens.

Most of us began our efforts spontaneously during 1977, working alone out of our kitchens with the primary concern for our own children. When I first discovered our teenage babysitter was using marijuana, I thought the answer to protecting my own 5- and 9-year-old sons was to separate them from any contact with drug-using youngsters. As I became more aware of the pandemic levels of drug use among children, I realized how futile this effort would be, and I also realized that most parents had as little knowledge as I had. I knew that to give my sons a chance to grow up drug-free, I had to help other parents understand how widespread and widely accepted adolescent drug use had become and get them involved in finding ways to prevent it.

The more I learned, the more concerned I became. The bright spot was that parents all over the country were beginning to organize spontaneously. We all encountered some problems of denial, but everyone cared. The early encounters with some schools were adversarial in nature, mainly out of frustration, fear, and anger on our part, and our parental demands that schools become drug-free.

We quickly learned that most principals and teachers were parents, too, and that when we approached them in a nonblaming way, they were far more willing to pitch in. Most would agree that drug use is widespread at and around schools—not because the schools want it this way, but because drugs are where kids are today, and kids are at school. They are also at camp, swimming pools, video game parlors, sports events, and even some church camps and trips.

Parties commonly include drugs and alcohol as "the event" or reason for getting together, and even the nonusing attendees accept drug use as normal behavior.

Behavior associated with drug-using teens reported to us by young people in treatment would shock anyone who cares about children. Not only do they commonly become dealers and thieves who steal from their own families and friends, they soon become alienated from most forms of authority, and many become prostitutes, both male and female, either because they need money, or because of a learned sexual promiscuity, or both.

Far more difficult to measure is the generally lowered achievement potential of these children, who drop from being "A" or "B" students to "C's" and "D's" and frequently drop out of school.

Adolescent drug use commonly pulls the family apart. We have had many calls also from corporations wanting copies of our "Parent Group Start Kit" to help organize their employees' communities, because some employees have become almost nonfunctional at work because of frequent arrests or school problems with their drug-using child.

It clearly affects all areas of society.

We are convinced that parents generally have been saying no to adolescent drug and alcohol use. However, in far too many cases, others in Government agencies, schools, counselors, and even some physicians have counseled the responsible use of these substances. During the seventies, most Government publications were still unclear on the dangers of marijuana use and their alcohol brochures for teens were directed toward the safe use of alcohol and just do not drive while drinking.

As parents, we became outraged that our tax dollars were being used to give messages to our children that directly opposed what we were trying to tell them at home. We feel we must give a unified message of "No drugs" or mind-altering substances for children and the community and government must back us up if we are to succeed.

The news media seemed far more attracted to statements from offbeat types like Timothy Leary or Norman Zinberg or Andrew Weil. I need to note, I think, that both Zinberg and Weil are members of the National Organization for the Reform of Marijuana Laws, the prodrug lobby that seeks to legalize marijuana. They have been organized for around 15 years. Andrew Weil's new book, "Chocolate to Morphine," includes such statements as, "There are no good or bad drugs, only good or bad uses of drugs. If you take PCP deliberately, avoid high doses." And on it goes.

Zinberg testified before the House Select Committee on Narcotics Abuse and Control that we, "should do the same thing with marijuana that we have done, let us say, today, about sex. That is, what we have tried to teach people is not to condone early sexuality, nothing like that. But we have said that if you are going to do it, let's show you how to do it safely."

Zinberg also served as the coordinator of the President's Commission on Mental Health and Psychoactive Drug Use or Misuse during 1978, and was on the Advisory Board of the National Institute on Drug Abuse during the same period. A statement from the President's task force that came from that committee in 1978 said:

> The task panel recommends that drug education and prevention strategies be aimed at the avoidance of the destructive patterns of psychoactive drug use and that an immediate cessation be imposed on the development of materials and programs aimed exclusively at prevention of all use.

These ideas are directly opposed to advice we are giving our children at home, and yet during that period, these ideas were clearly reflected in government publications, misleading hundreds of thousands of children into believing drug use is a harmless form of recreation.

The problem has been that until the National Federation of Parents for Drug-Free Youth was formed, no one spoke out in opposition. Even now, we are told Andrew Weil's book, "Chocolate to Morphine," is being used in the classroom at Aims College in Greeley, CO, as a text, and the University of Maryland School of Pharmacy recommends it as a resource. These are tax-supported schools giving information that clearly trivializes drug use. It is little wonder our young people accept drug use as the norm. They have been told by people that we have taught them to respect that drug use is OK.

However, we feel there is reason for optimism. We have come a long way since most of us began in 1977. The federation now serves as an umbrella for over 4,000 parent groups we have formed, representing every State in the United States. The National Federation of Parents Nancy Reagan Speakers' Bureau sends speakers to every State in the United States to educate and organize parents. Our members now serve on national and local committees, linking treatment and prevention efforts.

One of our board members writes a column, for instance, for King Features, that is now getting wide publication in major newspapers. We receive strong support from the Drug Enforcement Administration in our efforts to close drug paraphernalia shops and affect legislation in other drug-related areas.

The National Institutes on Drug Abuse and the National Institutes on Alcohol Abuse and Alcoholism are revising their materials under new leadership, to strengthen messages to children.

The National Federation of Parents has written and circulated its own materials to hundreds of thousands of citizens.

Service organizations like Lions, Elks, Kiwanis, and others, have joined the movement. Our friends on Capitol Hill have formed a group strongly supporting us called Congressional Families for Drug-Free Youth, that includes spouses from both sides of the aisle.

In communities where parents are organized, drug-free youth groups are forming, and the kids are saying, "We want it this way.

We did not want to be involved in drugs and alcohol. We need the support."

We feel that Government should be an extension of the people in our democracy, but we also recognize our responsibility as citizens in this democracy to make our positions clear, united and heard, and we will continue to do just that.

I, personally, believe that adolescent drug use is the most preventable problem that teens face, but parents must first be aware and organized to make prevention work.

We are proud to have the support of the President and Mrs. Reagan, who have both made clear statements that there is no responsible use of drugs by children. Mrs. Reagan has traveled extensively to speak to parent groups, visit treatment centers, appear on television, and has worked behind the scenes to ensure the best interests of America's children are protected in this area.

The National Federation of Parents for Drug-Free Youth is well aware that we have a long, long way to go. But Americans have always had a pioneering spirit and a protective concern for children. We must work harder and speak louder than those few people who would hurt anyone's children. We are receiving requests for our expertise now from around the world. Just this week, we had visitors from Venezuela and Norway, and in March, representatives from 16 Third World countries are coming to our offices to find out how we are doing it, because the problems are growing in their countries as well.

The Federation's 1984-85 theme is "Come On America, and Stick Your Neck Out for Kids—Help Stop Adolescent Drug Abuse." Our symbol is a giraffe, the lapel pins provided by McDonald's Restaurants last year at our conference. And we feel that we must convince America to believe in prevention and American businesses to support it. The most difficult task we have faced recently has been raising money to fund an organization that has been called by professionals an organization that has become the most influential force for the prevention of drug abuse in the country.

We invite each of you to stick your necks out with us, and we thank you again for the opportunity to make ourselves heard once again.

Senator DENTON. Thank you very much, Mrs. Nalepka.

[The prepared statement of Mrs. Nalepka follows:]

DRUGS AND YOUTH:
AN AMERICAN CRISIS

NATIONAL FEDERATION
OF PARENTS FOR DRUG-FREE YOUTH

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JOYCE DEE NALEPKA

Senior Vice President

NATIONAL FEDERATION OF PARENTS

FOR DRUG-FREE YOUTH

TESTIMONY BEFORE: Sub-Committee on Family and Human Services

February 24, 1984

Room 628 Dirksen Senate Office Building

HEARING TITLED: Parental Involvement With Their Adolescents in Crisis: The Federal Government's Response

Parent groups have unified into a nationwide parent movement, which has become the most influential force for the prevention of drug abuse in the country, affecting public laws, policies and attitudes.

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NATIONAL FEDERATION
OF PARENTS FOR DRUG-FREE YOUTH

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Mr. Chairman, Members of the Committee, Ladies and Gentlemen:

My name is Joyce Nalepka. I am Senior Vice President of the National Federation of Parents for Drug-Free Youth. I appreciate the opportunity to testify before you today.

While the focus of these hearings, "Parental Involvement With Their Adolescents in Crisis" will be far-reaching, I will be addressing, primarily, the issue of adolescent drug use. However, the experience we have gained in this area indicates clearly that many other adolescent problems stem from drug and alcohol use by children.

For instance, it has been estimated that 70 to 80% of teenage girls were under the influence of drugs or alcohol at the time of first sex. Teenagers commonly tell us they frequently tried suicide or thought of trying suicide while they were using drugs. Unfortunately, 5,000 children succeed at suicide annually and another 50,000 try. Adolescent crime is linked clearly and closely to drug use.

The National Federation of Parents was founded officially in May, 1980 with a sharply focused aim of educating parents, grandparents, educators, legislators, religious leaders, physicians, businessmen and others, using a non-blaming approach, for the prevention of adolescent drug and alcohol use.

The core of the National Federation is the parent/community peer group or task force which first becomes educated on the medical and scientific effects of drug use and then works to network the entire community into a safety net for children and teens.

Most of us began our efforts spontaneously during 1977, working alone out of our kitchens with a primary concern for our own children. When I first discovered our teenaged babysitter was using marijuana, I thought the answer to protecting my own 5 and 9 year-old sons was to separate them from any contact with drug-using youngsters.

As I became more aware of the pandemic levels of drug use among children, I realized how futile this effort would be and I also realized that most parents had as little knowledge as I had. I knew that, to give my sons a chance to grow up drug-free, I had to help other parents understand how widespread and widely-accepted adolescent drug use had become and get them involved in finding ways to prevent it. The more I learned, the more concerned I became. The bright spot was that parents all over the country were beginning to organize spontaneously.

We all encountered some problems of denial, but everyone cared. The early encounters with some schools were adversarial in nature mainly out of frustration, fear and anger on our part and our parental demands that schools become drug-free. We quickly learned that most principals and teachers were parents, too, and, that when we approached them in a non-blaming way, they were far more willing to pitch in. Most will agree that drug use is widespread at and around schools--not because the schools want it this way but because drugs are where kids are and kids are at school. They are also at camp, swimming pools, video game parlors, sports events and even church camps and trips!

Parties commonly include drugs and alcohol as THE EVENT or reason for getting together and even the non-using attendees accept drug use as normal behavior.

Behavior associated with drug-using teens reported to us by young people in treatment would shock anyone who cares about children. Not only do they commonly become dealers and thieves who steal from their own families and friends, they soon become alienated from most forms of authority and many become prostitutes (both male and female) either because they need money or because of a learned sexual promiscuity---or both.

Far more difficult to measure is the generally lowered achievement potential of these children who drop from being 'A' students to 'C's' and 'D's' and frequently drop out of school.

Adolescent drug use commonly pulls the family apart. We've had many calls from corporations wanting our "Parent Group Starter Kit" to help organize employees' communities because some employees have become almost non-functional at work because of frequent arrests or school problems with their drug-using child.

We are convinced that parents, generally, have been saying "NO" to adolescent drug and alcohol use. However, in far too many cases, others in government agencies, schools, counsellors or even some physicians have counselled the "responsible use" of these substances.

During the 70's, most government publications were still unclear on the dangers of marijuana use and their alcohol brochures for teens were directed toward the "safe" use of alcohol and "just don't drive" while drinking. As parents, we were outraged that our tax dollars were being used to give messages to our children that directly opposed what we were trying to tell them at home. We must give a unified message of "NO DRUGS" or mind-altering substances for children and the community and government must back us up if we are to succeed.

The news media seemed far more attracted to statements from "off beat" types like Timothy Leary or Norman Zinberg and Andrew Weil (Both Zinberg and Weil are members of the National Organization for the Reform of Marijuana Laws (NORML) the pro-drug lobby that seeks to legalise marijuana.). Andrew Weil's new book Chocolate to Morphine includes such statements as, "There are no good or bad drugs, only good or bad uses of drugs. If you take PCP deliberately, avoid high doses. The medical safety of marijuana is great...used occasionally, it is no more of a health problem than the occasional use of coffee or tea, and certainly it is less toxic than alcohol and tobacco." (No mention that the substance is illegal - or unhealthy.)

Zinberg testified before the House Select Committee on Narcoti Abuse and Control that we....."should do the same thing with marijuana, that we have done, let's say, today, about sex. That is, what we have tried to teach people is not to condone early sexuality, nothing like that. But we have said that if you are going to do it, let's show you how you can do it safely."

Zinberg served as the Coordinator of the President's Commissio on Mental Health and Psychoactive Drug Use/Misuse during 1978 and was on the Advisory Board of the National Institutes on Drug Abuse during the same period. A statement from the President's task force in 1978 said. "The task panel recommends that drug education and prevention strategies be aimed at the avoidance of the destructive patterns of psychoactive drug use and that an immediate cessation be imposed on the development of materials and programs aimed exclusively at prevention of all use."

These ideas are directly opposed to advice we are giving our children at home and, yet, during that period these ideas were clearly reflected in government publications misleading hundreds of thousands of children into believing drug use is a harmless form of recreation.

The problem has been that until the National Federation of Parents was formed, no one spoke out in opposition.

Even now, we're told Andrew Weil's book "Chocolate to Morphine" is being used in the classroom at Aims College in Greeley, Colorado as a text and the University of Maryland, School of Pharmacy recommends it as a resource! These are tax-supported schools giving information that clearly trivializes drug use. It is little wonder our young people accept drug use as the "norm". They have been told by people we have taught them to respect that "Drug use is OK."

There is reason for optimism. We've come a long way since most of us began in 1977. The Federation now serves as an umbrella for over 4,000 parent groups representing every state in the United States. Our members serve on national and local committees linking treatment and prevention efforts. We receive strong support from the Drug Enforcement Administration in our efforts to close drug paraphernalia shops and affect legislation in other drug-related areas. The National Institutes on Drug Abuse and the National Institutes on Alcohol Abuse and Alcoholism are revising their materials to strengthen messages to children. The National Federation of Parents has written and circulated its own materials to hundreds of thousands of citizens. Service organizations like Lions, Elks, Kiwanis and Junior Leagues have joined the movement. Our friends on Capitol Hill have formed a group strongly supporting us called "Congressional Families for Drug-Free Youth" that includes spouses from both sides of the aisle.

GOVERNMENT SHOULD BE AN EXTENSION OF THE PEOPLE IN OUR DEMOCRAC

However, we also recognize our responsibility as citizens in this democracy to make our positions clear, united and heard! We will continue to do just that!

We are proud to have the support of the President and Mrs. Reagan. They have both made clear statements that there is "no responsible use of drugs by children". Mrs. Reagan has travelled thousands of miles to speak to parents groups, visit treatment centers, appeared many times on television addressing the issue and has worked behind the scenes to insure that the best interest of America's children is protected.

The National Federation of Parents for Drug-Free Youth is well aware that we have a long, long way to go but American's have always had a pioneering spirit and a protective concern for children. We must work harder and speak louder than those few who would hurt anyone's children.

We are receiving requests for our expertise from around the world. Just this week we had visitors from Venezuela and Norway and representatives from 16 Third World Countries are coming in March to learn how to address the growing problem of adolescent drug involvement in their own countries.

The Federation's 1984-85 theme is "Come On America--Stick Your Neck Out For Kids--Help Stop Adolescent Drug Use." We must convince America to believe in PREVENTION and American businesses to support it. We invite you to join us. Thank you.

Senator **Denton**. Mrs. Nalepka, you mentioned the suicide situation, with 5,000 succeeding at suicide annually, another 50,000 trying. I have heard that suicide is the second-rated cause of death among teenagers, second only to drug abuse-related automobile accidents.

Do you happen to know whether that is true?

Mrs. **Nalepka**. Yes; I believe that is from a report from the Surgeon General's Office, that states in addition that the age group of 15 to 24 is the only age group whose lifespan is not improving, but declining, and the three major causes are traffic-related accidents that are drug- and alcohol-related, suicides, and homicides, in a time in these children's lives that should be the happiest time of their lives

Senator **Denton**. What would you say is the most difficult task your organization faces?

Mrs. **Nalepka**. I think convincing parents to come out of the denial and out of that innocent belief that we all wanted to have, that, "It won't happen to my children." That is one. The other is raising the money to make this effort go.

I just was playing with some figures, coming down on the subway. Parents tell us that it costs from $10,000 to $25,000 per child per year for treatment, depending on where you take them. So $500,000 would save 20 children; $500,000 is about what our annual budget is, and we serve over 4,000 groups of parents and communities that primarily are made up by volunteers, where one mother in a town can organize a whole town, and perhaps, save a whole community of children.

Senator **Denton**. Do you have any suggestions about how parents might control alcohol and drug teen parties?

Mrs. **Nalepka**. Yes, I do, and it is a very simple one. It is called, "Pick up the telephone."

Senator **Denton**. Called what?

Mrs. **Nalepka**. Pick up the telephone. If your child comes home and tells you that he or she is invited to a party, call the parents of that other child and ask, "Are you in fact having a party? Are you going to be home? What are you serving?"

And the kids are not going to like it in the beginning, but once all parents begin doing that, or forming a parent support group that is based on the friendship circle of your children, it is far more important to know the parents of your child's friends than to know the children, perhaps. Get together and talk to each other about what do you want for your child's teenage years. Set down some reasonable guidelines that are appropriate for that age group, and then enforce them. It is called adult peer pressure. The kids tell us all the time about peer pressure, and it is sometimes an excuse for bad behavior. It can also be an excuse for good behavior. And parents need to use it, as well. It works, and the kids eventually—not immediately, usually, but eventually—will say they are having a lot more fun.

I spoke with a group of parents just last evening, and there were several parents who appeared to be afraid to confront their children—"What do you do? How do you keep them from going to these parties where you know drugs and alcohol are going to be present?"

You simply say, "You don't go." But you hold alternative parties. And the kids will come, and if they are organized, and there is enough fun there, they will come. It is not enough to tell your kids, "Just don't drive." The only responsible answer is "No" to both alcohol and drugs for school-age children.

Senator **Denton**. I am in another subcommittee, of which I am chairman, finding myself overseeing the Drug Enforcement Administration. But in that oversight, frankly, I had not come across the information that we had government informational pamphlets, or whatever you want to call them, that advocate responsible use of drugs, and so forth. That shocks me.

However, I can assure you, from my association with the sexuality advice and movies and so on, given by some of the heaviest-funded government programs, that your gentleman who said that what we have tried to teach people is not to condone early sexuality—nothing like that—he is incorrect. He is not aware, as I am, of the fact that they not only condone it, but effectively encourage it. There is at best a value-free approach to most of that government-funded advice. That is why the parent needs to know about it. That is why even Dr. Zinberg needs to know that it is worse than it is.

That is why, when they saw the most popular movie put out by one of those funded organizations, the Labor and Human Resources Committee unanimously voted out my bill the Adolescent Family Life Act, which was lampooned by Doonsbury in the Sunday comics.

We do have an ignorance of what the program is and an ignorance of what the problem is.

Mrs. **Nalepka**. I would like to say also that the drug and alcohol brochures are currently being revised. The only unfortunate thing is that hundreds of thousands of them are out there, and apparently there is no recall process.

A comment on the Doonsbury column. The National Organization for the Reform of Marijuana Laws, Gary Trudeau is a supporter of theirs, and we used to read the column with great interest and it always—generally, frequently—trivialized drug use. And when we learned—we were told that he was donating his artwork to support NORML—I called the Washington Post and asked if they would clarify that, and they called the syndicator, who said, "Yes, it is true." So there is a network.

Senator **Denton**. Did they print that? Did they find that worth printing?

Mrs. **Nalepka**. They printed it in the "Ombudsman" column, very closely on the inside of the paper. Not many people saw it unless we called their attention to it.

Senator **Denton**. Well, I am hoping that these Government-funded organizations in the field of sexual counseling do the same sort of thing that you are talking about that is now being done in the drug related field, that is, that they correct the trend. Many of them who have belonged to those organizations have come to me with tears in their eyes and said, "You know, you are right. We have been fouling up those youth, and we are going to change." And I am hopeful about that.

Mrs. **Nalepka**. I believe very strongly that if you give the children the truth in a caring, consistent way, whether it is on drugs or sexuality, they will believe you. They do not need scare tactics; they need the truth. And off-the-record, as an individual, not necessarily representing my own broad-based organization, I would say that surely, there are physicians in this country who can prepare pamphlets for teenagers, explaining to them good, sound medical reasons why teenagers should not be involved in sexuality.

Senator **Denton**. How has the Drug Enforcement Administration assisted parents in their campaign for drug-free youth?

Mrs. **Nalepka**. Well, when we were trying to close drug paraphernalia shops nationwide, they loaned us their expertise and actually wrote a model law that we could use nationwide. We introduced it and passed it in Maryland, wrote a booklet on how we did it and how we organized the community, and sent it to all 50 U.S. Governors, and then someone wrote an article about us in the "Ladies' Home Journal." We received 1,000 orders for the book, and the bill has now been passed in 36 states, I believe, and introduced in the remaining 14.

Senator **Denton**. Thank you very much, Mrs. Nalepka, and if our next witness, Dr. Stephen Van Cleave, cares after his opening statement to testify regarding any of the questions addressed by Mrs. Nalepka, feel free, and also you, Mrs. Nalepka, as I ask Dr. Van Cleave questions, I hope you will feel free after his answer, to add anything you care to.

Dr. Stephen Van Cleave is the medical director of TOUCH, a drug treatment and rehabilitation program in San Antonio, TX. Dr. Van Cleave will discuss parental involvement in his organization's efforts to treat the problem of substance abuse.

Dr. Van Cleave?

Dr. **Van Cleave**. Thank you, Senator Denton, for the invitation to testify this morning. My testimony is on the basis of 14 years in the drug rehabilitation field. I do serve as the medical director of the TOUCH Drug Rehabilitation Program in San Antonio, which is a nondenominational, Christian-based drug rehab ministry, in addition to my practice of medicine, which is how I support myself.

I would like to briefly review the drug problems that we have among teenagers and adolescents—and I certainly concur with what Mrs. Nalepka had to say.

Surveying 1980 seniors who graduated that year, the National Institute of Drug Abuse found that 93 percent had used alcohol during their senior year; 60 percent, marijuana; 26 percent, amphetamines; 10 to 18 percent had used heroin, cocaine, sedatives, or hallucinogenic drugs. Now, those were cumulative totals during the year and do not represent what everybody used all the time. However, 6 percent of the seniors admitted to using alcohol on a daily basis, and 9 percent, marijuana.

Those numbers may not seem too bad, but also in the survey, within 2 weeks of the survey 41 percent of teenagers—and this is a survey where they admit their drug use; it is a private-type thing where they fill out the data—41 percent indicated that they had been intoxicated with alcohol within 2 weeks of the survey, and 33 percent within 4 weeks of the survey, marijuana.

So we are talking about quite a large number here.

In the epidemiology of drug abuse, we need to remember that in some ways, drug abuse is like an infectious disease. Where drugs are available, the amount of trafficking in illegal drugs is anywhere from $60 to $100 billion a year, more so than the total revenue of the major corporations such as Exxon and General Motors. When I use the term, "infectious disease," what you are talking about is that you have a host, which is the person who becomes ill, susceptible in the presence of the infecting agent—in this case, it would be drugs.

It is interesting, though, that the most potent preventive to drug abuse, in all of the different studies that have been performed, as well as our own cumulative data over the past 14 years, is a strong family. A strong family unit will overcome the presence and influence of negative fears. It also, even in ghetto situations, has a protective effect against the environment, so those folks who say that a ghetto-type environment is always going to lead to drug abuse are wrong, in the setting of a strong family unit.

There are, though, family factors that do contribute to drug abuse, and you cannot look at adolescent drug use without looking at the family. And some of the most telling things include, in our own patients that we work with, 25 to 40 percent of the families, depending upon the period of time that we have surveyed, had one parent who was actively using either alcohol or another drug.

Disturbed parental-child relationships are very common, including frequently a hostile relationship with parents, a mother who tends to be emasculating; lack of closeness in the family; discipline that is either weak or nonexistent, or excessive, not a middle balance of positive discipline, but either very weak or very punitive; vague or absent parental standards for how the parents live their lives; lack of a strong father figure, either because the father is absent due to divorce or always involved in his job, or a very passive father, who does not take a leadership role; poor marital relationship between the husband and wife; concentrated stress in terms of turmoil in the family due to illness, inability to get along between parent and child, or the parents.

Stress itself is not harmful, as long as people have rest from the stress. In terms of the body's own mechanism, strengthening of, let us say, a muscle group, is best done by intermittent periods of stress, making the muscle work harder and then allowing it to rest. The same is true in the way people live. People can grow emotionally if they have periods of stress, but are allowed periods of rest in between.

Other factors in the family that contribute to drug abuse include the fact that mothers are overly attached to their children and will not let them go so they can become independent and learn how to live independently, as they are teenagers. The drug user is frequently treated as the "black sheep" of the family and he is inferior to other family members. All this does is tend to drive his self-esteem even lower and encourage his use of drugs, as well as emotional support by the drug-using peer culture. Another factor in this, and one of the things we have seen, is that drug use in the adolescent years reverses the emotional maturation process that takes place, and most drug users that we work with, even though they may be adults, have the emotional maturity, let us say, of an 8- to 10-year-old. My two older daughers, who are 10 and 11, who go with me frequently to the drug programs, even have commented to me about this, that they can see this emotional immaturity. And I can compare my daughers, in terms of their level of emotional growth and interaction, with some of the drug users that I work with.

Another factor, though, about families is that even though the family itself may be dysfunctional, the drug user will tend to remain in the family and support the family, because a bad family is better than no family at all.

Finally, parents—and Mrs. Nalepka was alluding to this—often deny the problem of drug abuse, and also deny what role they may play as parents in terms of encouraging or supporting drug use.

Dealing with drug abuse in a family setting—what are some of the key things that we have come across?

One, the first and most important thing is that the parent has to admit that the problem exists. Until the parent admits the problem exists, we find there is nothing that can be done.

Then, second, a willingness to deal with the problem. When we have calls by parents that they have a teenager with drug problems, the first thing we ask them is, "Are you willing to work with us with your child?"

If they are unwilling, we have to tell them that we cannot help them until they are willing. For one, if their adolescent is not in a structure where the parents support that adolescent in his getting help, he will not even want to come. He will not even want to participate. He will not follow any suggestions or guidelines in terms of getting off the drugs.

Another factor is that the parents themselves have to set standards for the family, and those standards have to be standards by example and leadership, rather than, "Do as I say, not as I do." If you have drug-using parents—and I am including alcohol here—it is very easy for the teenager to use that as an excuse not to deal with his drug problem and say, "Well, what is wrong with my pot? My folks get drunk every weekend."

Another factor is control of peers. As Mrs. Nalepka was saying, the parents have to work together to know where their children are, to know who is doing things, who is giving parties, and the parents have to band together to provide an environment that can exclude drugs. Another thing is that the children have to understand that drug use is not an option, period. There cannot be any vagueness about that. And this requires that the parents are going to have to be tough, which is not always easy. Mark Twain said that when a child turns 13, he should be "put in a barrel and fed through a knothole, and when he turns 14, you should plug up the knothole." That was his approach to parenting.

Emotional support needs to be given. One of the reasons that kids get into drugs and stay into drugs is that they get more emotional support from their drug peer culture than they get at home.

Finally, I would like to mention some approaches that are successful, working with adolescents in terms of helping them to get off drugs and stay off drugs.

One is the parent peer group approach that Mrs. Nalepka has very well briefed the subcommittee about.

Another is an approach by an organization called Straight, which has several programs in cities in the Eastern United States

Straight's approach is to take a drug-using child and put him in protective custody of the program. They stay at the program location most of the day, and even into the early evening. At night, they are in the custody of a drug-free peer, and they stay at that drug-free peer's house at night. They are totally locked out of their own home. They are kept in the Straight program and prevented from having anything to do with their family until they have an open meeting, where the child has to admit to this entire open meeting of other drug peers, drug-free peers, and parents, his drug problems and has to admit to his family what his problems have been and the fact that he has hurt the family. After a certain period of time, when the child has made a decision that he will go without drugs and has proved that his decision is real by his lifestyle, is he allowed to go back home.

One of the things that Straight requires is that the parents have to participate in the project, and the parents also have to, openly before the group, deal with some of their problems—a very difficult thing, but also very cathartic, and the parents get support. They realize they are not the only ones with a drug-using child, that it is not a matter that the parents are all wrong and messed up, and the child was an innocent victim.

Our own approach at the Touch Program, we have two phases of our program. One phase works with teenagers and their families. Most of these teens were referred to us either through their school or their church, and we work with them only in the setting of the parents—and both parents come, not just the mother, but both parents—and the teen. Standards are set for the family, guidelines, and over a period of months, these guidelines and goals are worked on, one by one. And we have had very good success when the teen is worked with with both parents. When we find that the parents are unwilling to come, the success rate is pretty dismal.

In the adult area we work with—and these are primarily heroin addicts—one of the things that we do—50 percent of the male addicts in our program still live with their mothers. We tell them we have to interact with their mother or their wife, if they are living with their wife, because for them to become drug-free, they have to have the appropriate emotional support of either their mother or their spouse, and that support includes the spouse or mother being willing to be tough about drugs, being unwilling to support the drug habit, being unwilling to support irresponsible behavior.

In summary, I would like to say that parents are the key to adolescent rehabilitation, and we are talking about either natural parents or, in some cases, surrogate parents. Certainly, there are families that are so discouraged and so broken that the child is going to have to be out from under that setting and get the love and support of another parent or another person to help that child out of the drug life.

One last comment I would like to make. In the media, there are lots of comments about the tremendous cost of drug enforcement policies, about whether or not trying to interdict the drug supplies is really helpful, that they are just getting the tip of the iceberg, and so many billions of dollars of drugs get through anyway, and what if we just legalize these drugs or put taxes on them and we gain revenue. Every effort that the Federal Government puts forth to reduce the amount of drugs available will ultimately lead to fewer children getting onto drugs.

Thank you.

Senator DENTON. Thank you, Dr. Van Cleave.

[Responses of Dr. Van Cleave to questions submitted by Senator Denton follows:]

Questions for Van Cleave:

1. Dr. Van Cleave, you mention that treatment of adolescent drug abusers is much more successful if the entire family gets involved in the rehabilitation. You've discussed the positive aspects of this family involvement, are there problems or difficulties that arise when the family becomes involved in the rehabilitation?

Answer to Question #1:

Not all family involvement is positive because some families have a psychological need for a "black sheep", and they will consciously or subconsciously act in ways that maintain the drug using behavior of the adolescent. Also, if the mother is dominant she will see herself as protective, and will frequently become too involved in the life of the adolescent...bailing him/her out instead of allowing him/her to work through the problems on his/her own. Then there are those families who blame the drug use solely on the child, and deny that there is any family pathology that could be part of the problem. Their attitude is "fix my kid, but leave me alone".

2. Dr. Van Cleave, some of the literature you cite indicates that many adolescent drug abusers are from families in trouble--that is, where there is a poor relationship between parent and child or between parents, or where there is parental tolerance of the drug abuse. How can the family be brought into the treatment process if there is family tension or disinterest on the part of the parents?

Answer to Question #2:

To ask for participation is not the best approach that will work in the majority of cases. However, if you make it mandatory through the court, or as a condition of treatment in a drug treatment program you will be able to bring a greater number of families, or family members into the treatment process. Without leverage parents are unlikely to participate.

Senator **Denton**. I cannot help recalling Dr. Strommen's reference to the two extremes on the parts of parents in dealing with their children in terms of discipline, one being totally autocratic and dictatorial, and the other being too permissive, and sort of a democratic—I think he used the word, "authoritative," or something like that—one being perhaps the best, as he could see.

The reason that occurs to my mind is that there was a chaplain who was supposedly the best expert on drug addiction, treatment and so on, in the armed services. He served first in the U.S. Navy, and then all four services, all four branches. He had something like 28 years of experience when he began lecturing at the college of which I was commandant. He said that one conclusion of which he was utterly confident, and that statistics bore him out in every case, was that the greatest percentage of alcoholics came from families in which alcohol was barred as a sin, as it were, during childhood, adolescence and even adulthood.

Dr. **Van Cleave**. I will concur with that.

Senator **Denton**. You will concur with that? That is very interesting, because I wondered if there was a difference there. That confirms it even further with me, because I would have thought, coming from your particular genre of thought, a nondenominational Christian, that you might be of those who think it is a sin, et cetera. But according to him, and he was a very moral man, those who tried to rule alcoholic indulgence out entirely in homes—although perhaps, sometimes, hypocritically—and hit the kids hard with it did produce the highest number of alcoholics. He mentioned, for example, Jewish children, who are permitted to drink wine at a very young age, and you find an extremely low proportion of alcoholics among the Jewish people. He mentioned the Baptists and other denominations, which deny alcohol probably most autocratically, and said that they had the highest percentage as adults. Now, that is what he said.

Dr. **Van Cleave**. I would like to make a comment on that.

Senator **Denton**. Yes, please.

Dr. **Van Cleave**. Some of that may be the fact that things that are forbidden to the adolescent are very attractive. Our own approach to drug education in San Antonio is that we only go to talk about drugs with an addict in treatment or an exaddict, and we let the addict himself communicate to the kid what his life is all about. That does nothing to encourage drug use, because there is a certain, nonverbal communication they pick up, that here is a person whose life has been at this point destroyed by drugs.

Education itself that says "Drugs are bad" only encourages the curiosity of the adolescent to say, "Well, they all say it is so bad, but I think I am tough enough that I can handle it."

Senator **Denton**. Well, we are getting into an area in which I have heard so many children and adolescents and older youth discuss, and that is, can we truly equate in every sense—although recognizing that alcohol is a drug—you start out by saying that having a beer is the same as having a joint, and then you go from marihuana being no different from another kind of drug, and you get to Dr. So-and-So that Mrs. Nalepka quoted, who said, "There is no such thing as a bad drug; it is only irresponsible use." And I wonder if that is a series of syllogisms that we want to usefully employ, that beer and marijuana are pretty much the same.

Dr. **Van Cleave**. Well, medically, they are different drugs. My own approach to alcohol is that I abstain. And I tell my children that alcohol, when used appropriately, is not dangerous to people's health, but I tell them that because I work with drug addicts, I have to set a certain example. You know, at times, my children have a hard time understanding that, because they see the results in the addicts, so they tend to be maybe a little bit more reactionary at that childhood level. But I explain to them that it would be hypocritical of me to work with the addicts, who also frequently have alcohol problems, as well as other drugs, and to just say, "It is OK for me to use it but you can't"—I have to set an example partly because, with their emotional level being very childlike, rational logic would not work.

But alcohol is a very short-acting drug. In 24 hours or less, it is completely eliminated from the body. Whereas marijuana, because it is dissolved in fatty tissues, which make up a great percentage of the brain tissue, remains in brain tissue for a minimum of 3 to 5 days to perhaps as long as 2 weeks or greater. So, for one thing, marihuana remains in the brain much, much longer.

Alcohol in small doses seems to have a relaxant effect, but does not seem to impair people's ability to think or to concentrate. As you approach the legally intoxicating level, which would be 100 milligrams percent; in most States, you find impairment of judgment and motor skills. However, the level that people can have alcohol, let us say one beer, would be far less than that.

Marijuana, on the other hand, impairs judgment of motor skills you cannot quantify or regulate how marijuana affects the brain. People do get somewhat of a degree of sedation, but they also have interference with reasoning, in terms of complex logic and working their way through problems. And they have a false perception, because of their marijuana intoxication, that they are actually better off emotionally and intellectually.

It is one of those things where a person can have a beer and not become intoxicated, but it is difficult for a person to have a joint and not become intoxicated.

Mrs. **Nalepka**. Marijuana is a much more complex drug than alcohol. We are talking about alcohol, with a single chemical.

Dr. **Van Cleave**. Marijuana probably has 30 different active ingredients that have some effect on the brain.

Mrs. **Nalepka**. And there is a total of 421 chemicals in the substance that we are told interact to make as many as 2,000 when it is burned. So we are talking about alcohol as a substance that leaves your system in 12 to 24 hours, and marijuana, that continues to collect. And even with alcohol, the teens that we have talked to in treatment—I am sure Dr. Van Cleave probably has seen this himself—with alcohol, they drink a lot differently than we did, growing up, maybe at 16 or 17 or 18, when it was a big deal to split a beer three ways. These kids are going out to get absolutely blasted, and they are timing each other to see how long it takes for one kid to drink a sixpack or two sixpacks.

Senator **Denton**. Well, I have no doubt that both problems are much more severe than they were when we were growing up—if I can imply that you are as old as I am, Joyce——

Mrs. **Nalepka**. I think we are pretty close.

Senator **Denton** [continuing]. And more widespread. The degree of abuse is greater. It is a social crisis in our Nation; liberals and conservatives agree on that.

I just wonder if our generalization that alcohol is a drug, marijuana is a drug, heroin is a drug, cocaine is a drug, and then to distinguish among them by talking in terms of how many chemicals are in each is quite the kind of discussion we would want to have in trying to clarify the thing to teenagers.

Wouldn't it be more useful to say on a scale of 10, one is this, one is that, one is the other, and abuse of any is bad, or something a little more simple?

Mrs. **Nalepka**. Really, I am not sure that we can, because the kids are doing polydrugs. They are not doing any one drug today. They are mixing all kinds of drugs. And the National Federation of Parents, the only way we felt we could address the issue and have any success was to target school-age children—we do not even get into the issue of adult use of alcohol—with the side hope that parents, too, will begin looking at their alcohol use more responsible, and not drive, but that is not an answer for children. The only answer for children is no use.

Senator **Denton**. In every case, we have been hearing the favorable effect of strong family on any problem which we have discussed today, and we are in an era in which single-parent families are forming at 20 times the rate of two-parent families. We have also admitted that a single-parent family is not the worst thing in the world, but certainly not as good as a two-parent family. So the one-parent families need some help, and my own perspective is that we should have policy that does help the single-parent family. We should have policy that helps the two-parent family that is in trouble, to stay together, and that we should have policies that lower the probability that they are going to get in trouble in the first place and that their kids are going to get in trouble in the first place. In other words, why contribute to our already native evil that we have intrinsic in us to some degree—why should Government policy add to that set of temptations, rather than attempt to subdue it, as most anthropologists and historians have stated is a matter of necessity if we are going to have a society or a nation.

Mrs. **Nalepka**. Single parents tell us that the parent peer group is one of the most positive things they have ever gotten involved in. It means that as a single mother or father, if you have a child with a problem, you can call the parent peer group and say, "Look, I can't deal with this. Can you come over and help me?" They get more support, or probably at least as much, as families where both parents are present.

Senator **Denton**. Well, thank you both very much, Mrs. Nalepka and Dr. Van Cleave. We will be submitting questions to you in writing and ask that you reply to us as soon as you can. Thank you very much.

Our third panel consists of two witnesses concerned with the mental health of adolescents. Mrs. Carol Howe is the president of the Alliance for the Mentally Ill of Montgomery County in Maryland. She is also to testify on behalf of the National Alliance for the Mentally Ill. Dr. Richard Wilmarth is president of the American Mental Health Counselors Association, and he is from my home State of Alabama.

Good morning to both of you, and Mrs. Howe, would you proceed?

STATEMENT OF CAROL HOWE, PRESIDENT, ALLIANCE FOR THE MENTALLY ILL OF MONTGOMERY COUNTY, ON BEHALF OF NATIONAL ALLIANCE FOR THE MENTALLY ILL, WASHINGTON, DC, AND DR. RICHARD WILMARTH, PRESIDENT, AMERICAN MENTAL HEALTH COUNSELORS ASSOCIATION

Mrs. HOWE. Yes, I would be glad to.

Senator Denton, and those gathered here, I have some brochures on mental illness that I would like the people here to have, and I will give them out, and also, I would like them to be put in the record.

I also have a longer statement that I have submitted for the record, and this is my oral testimony, which will be a little different.

Senator DENTON. Your longer statement will be included in the record.

Mrs. HOWE. Good. Thank you very much.

Mr. Chairman, good morning. I am Carol Howe. I am glad to be here this morning. I believe that each of us who has lived with the tragedy of severe mental illness must tell others about it, what it is like, and what needs to be done about it.

My husband and I are the parents of four beautiful children, all adults. Two of these adult children have the diagnosis of schizophrenia.

Today, I want to talk about five things. One is what is severe mental illness; two, some of the arithmetic of mental illness; three, the impact of mental illness on families; four, what is happening to families and their adolescents in school; and five, I will tell you about the Alliance for the Mentally Ill.

Severe mental illnesses embrace a number of diagnoses, but generally, we think of the schizophrenias, manic depression, and severe depression as the bulk of the mental illnesses that may last a long time. They are diseases of the brain, the causes of which are not yet well-understood, though evidence is mounting that the causes are biological in origin.

Mental illness such as this is not the result of early bad parents, or teachers, or poverty, or neglect of emotional problems early on.

There are active and passive symptoms. The active symptoms may include some or all of the following: thought disorders that prevent the victim from carrying through a line of planned, logical thinking; hallucinations: i.e., hearing, seeing, feeling, smelling, or tasting something that does not exist; delusions: i.e., fixed, false beliefs; and mood swings that may go in cycles, leaving the person usually high or depressed. These moods may include anxiety, anger, bewilderment, deep depression, or euphoria.

The passive symptoms may continue after medication has alleviated or removed the active symptoms. The passive symptoms may include ambivalence, lack of motivation, shattered self-confidence, unreasonable fears, a flat or blunted emotional response, and poor ability to organize one's life.

The arithmetic. The National Institute of Mental Health estimates that there are between 10 and 14 million Americans with disabling mental illnesses, that is, the serious ones. Severe mental illness occurs in all economic and ethnic groups. It costs billions of dollars nationally in care and in lost earnings. More Americans suffer this disease than any other major disease, and more hospital beds are occupied by this group than by those suffering from any other disease.

Because there are few community support systems, many of our mentally ill are ending up on the park benches, wandering, and sick. Severe mental illness strikes our young. The onset is usually in late adolescence or early adulthood. The largest number of severely mentally ill persons falls between 18 and 35 years. Fewer research dollars are spent on these diseases than on cancer or heart disease. In 1983, $168 per patient with cancer was spent on research, and only $7 per person with schizophrenia.

Many of our mentally ill young, not knowing where to turn when their heads are not working the way they had, turn to drugs to self-medicate.

Impact on families. Mental illness affects the family in ways similar to other catastrophic illnesses. It is devastating. Confusion, guilt, fear, anger, frustration, shame, loneliness, grief—all of these emotions come to the fore. When families first become aware that a loved one in their family is acting in a different way, there is an all-pervasive anxiety. There is confusion. "What shall we do? To whom shall we turn? What did we do to cause this? Where did we go wrong? What will our friends and neighbors think? We cannot turn even to our own family." All the old, unhelpful, scarey labels come to mind: "My daughter is mad or insane or crazy." The family hurts for their child, and they hurt for themselves. They fear that their loved one may harm himself or harm others. Stigma causes the family to isolate themselves.

The ever-recurring questions without answers sometimes numbs them and keeps them from taking action.

Up until recently, there has been no one with whom families could talk. The loneliness and isolation of families of the mentally ill made their sorrow worse. Fortunately, in the past decade, mutual support advocacy groups, the alliance for the mentally ill groups, have grown up and given families of the mentally ill a forum for mutual support and comfort. Sometimes internal strife about a mentally ill child and what the best kind of treatment is has caused parents to separate. In others, it has caused the relationship of husband and wife to grow even stronger as they seek to find help for their child.

Shoddy treatment by providers. It seems that in no other disability is the family so shoddily treated as they have been by the very profession that should be caring. For decades providers were trained in the psycho-analytical mode. If a child turned up with a mental illness, they were taught that it must be the family's fault.

For example, communication theory taught that parents caused mental illness by not communicating well.

So, when we go to providers to get help or to learn what is going on, our telephone calls are unanswered, and a wall is thrown up. Families are alienated, and either blamed or ignored.

Recently, however, new fads have popped up. It is now "in" to involve the family with the mentally ill member, but not as families of other catastrophic illnesses are treated, with dignity and respect and in an educational mode, but rather, families of the mentally ill are assumed to be ill, and their involvement is to give them treatment or so-called family therapy.

Families do not want to be ignored, nor do they want to be treated as sick. They want to be treated as any other family with a child who has been stricken with a catastrophic illness. They want to be involved, to help their child. They are good people to be involved, and they are often the only support system he or she has.

The financial impact on families is enormous. Families who do have medical insurance find that it soon runs out. Some hospitals keep the ill member until the insurance runs out and then say he is well.

Prudent families will husband their insurance dollars and ask exacting questions, but all too often, facilities are recommended by private psychiatrists, and the novice finds himself inextricably tied to a given facility without a diagnosis, without any knowledge of how long the treatment will last nor what it will cost. Many professionals seem unable to share both their knowledge and their ignorance of mental illness with the families, and hence, both the professional and the family may ease into the old expectation that where there is treatment there is, per force, cure.

Families are led to believe that if they spend enough money, or their patient listens to enough talk therapy, or if he or she takes enough medication, then surely, there must be a cure, and the financial burden is astronomical. Insurance dollars have dwindled, and because many providers have used up insurance dollars on long, expensive analyses, or on people who have problems in living rather than on people with real mental illness, insurance companies have cut benefits.

Families want education. They want to know about the illness of their son or daughter. They want a diagnosis. They want providers to tell them what is known about the illness, and they want them to tell them what they do not know. They want to know about coping skills.

In Montgomery County, 72 percent as young adults return home from a State hospital, so families have been thrust into the role of primary caregiver without education and without respite, because there are so very few community facilities such as housing, and a meaningful day's occupation for these people to go to.

Just a little bit about school. Public Law 94-142, the Education for All Handicapped Children Act, mandates that all handicapped children must have an individualized education plan, IEP. According to the law, the family must help in the formulation of that plan. Here again, families re often ignored, and are given the plan as finished, when in fact, they may have a great deal to contribute to the planning of their adolescent's future. Families must judge whether a program is merely custodial, or if there is real growth possibility. Families need to work toward inter-agency collaboration. They must insist that the vocational rehabilitation agency is working in high school to bridge that awful chasm that exists when school is no longer available because the child has grown to the age when the Public Law 94-142-mandated educational program expires. At that point, there is literally nothing in the community for him to turn to. There is no housing, no supportive day services, no job training, no support for the family—only abundant stigma.

One of the things we have found is that the community mental health centers have not helped our people. We want the dollars that go to the community mental health centers to give the kinds of services that our people need—not just a 50-minute hour. They need housing, they need case management, they need a meaningful day's occupation. It is tremendously important because this is not available for them.

Many of us with hindsight lament that our schools did not give our mentally ill adolescent a marketable skill while he was in high school, something he could turn to and do when his illness is in remission. Vocational education is paramount.

Now I would like to tell you a little bit about the National Alliance for the Mentally Ill. It was born in Madison, Wis., in 1979, when representatives of self-help groups of families met and discovered that 80 such self-help groups had formed across the United States, unknown to one another. Since that time, we have grown to 270 such groups in 47 of the 50 States, and we have 15,000 members. We doubled our strength in the past 18 months. Such is the measure of the need, of the anguish, of the determination of these stricken families.

Typically, these groups provide four services. First, they give emotional support to the families by reassuring them that they are not alone and that they did not cause the illness. They make it possible for families to accept that they have a real problem that will not go away, that must be dealt with, and they help each other with practical problems, in managing, and coping with a mentally ill member.

Second, they educate the families about mental illness and about the several hotly contended theories on treatment. The family must have this education because they must choose among those competing treatment modes when they choose a doctor or a hospital.

Third, they monitor the performance of providers and give them feedback on their work—good or bad—feedback that is welcomed by the providers with good egos.

Fourth, they educate the public about mental illness, trying to counter some of the myths and misunderstandings spread by the press and by the movies and other media, and to promote sympathetic understanding and support.

And finally, and very importantly, they advocate at the local, State, and national level for fair treatment of the mentally ill, for quality care in the hospitals, for supportive services in the community, that will enable the ill person to leave the hospital when hospital care is no longer needed.

And not least in our advocacy is our determination to declare a war of research on mental illness so that as soon as possible, we know the causes of mental illness and how to prevent it from happening, and how to treat it if it does strike.

Thank you very much.

[The prepared statement of Mrs. Howe with attachments follows:]

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TESTIMONY

ON A SENATE RESOLUTION

ON THE INVOLVEMENT OF PARENTS OF ADOLESCENTS

ON CARE, TREATMENT AND COUNSELING

BEFORE THE

SUBCOMMITTEE ON FAMILY AND HUMAN SERVICES

OF THE

SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

SUBMITTED BY

THE NATIONAL ALLIANCE FOR THE MENTALLY ILL

PRESENTED BY

CAROL HOWE

PRESIDENT, ALLIANCE FOR THE MENTALLY ILL OF
MONTGOMERY COUNTY, MARYLAND

THE MENTALLY ILL AND THEIR FAMILIES' PARENTAL INVOLVEMENT WITH THEIR ADOLESCENTS IN CRISIS: THE FEDERAL GOVERNMENT'S RESPONSE

Mr. Chairman, Members of the Committee:

Good morning, I am Carol Howe, 10808 Clermont Avenue, Garrett Park, Maryland. I am glad that I was asked to be a member of this panel. I believe that it behooves each of us who has lived with the tragedy of severe mental illness to tell others what it is like and what needs to be done about it. My husband and I are the parents of four beautiful children. Two of these adult children have the diagnosis of schizophrenia. My presentation will focus on the mentally ill and their families.

- The National Institute of Mental Health estimates that there are between 10 and 14 million Americans with disabling mental illnesses.
- Mental illnesses are diseases of the brain, the causes of which are not yet well understood -- though evidence is mounting that the causes are biological in origin.
- Many mental illnesses are treatable through medication and can be improved through a well-designed community support and treatment system.
- Severe mental illness occurs in all economic and ethnic groups.
- It costs billions of dollars nationally in care and in lost earnings. More Americans suffer this desease than any other disease and more hospital beds are occupied by this group than by those suffering any other disease.
- The three major illnesses that make up the bulk of the severe mental illnesses are schizophrenia, manic depression and chronic depression.
- Severe mental illness strikes our young. The onset is usually in late adolescence or early adulthood. The largest number of severely mentally ill persons falls between 18 and 35 years.
- Fewer research dollars are spent on these diseases than on cancer or on heart disease. In 1983 $168.00 was spent on research per patient with cancer and $7.00 per person with schizophrenia.

The Family Involvement in Mental Illness

When a family discovers that it has a mentally ill member, it typically goes through three distinct phases. The *first* is one of grief, fear, anger, bewilderment and retreat from social contact -- hiding the illness from self, neighbors, friends and the larger family and hoping it will go away. *Second*, families accept that the illness is not going away and they seek help and enlightenment. A few families (or sometimes just fathers) never migrate to this stage but continue to disavow the illness, even rejecting the ill person -- thinking of him or her as bad rather than ill. In the *third* phase, families seek to change the social system to make a fair place for the mentally ill just as other disability groups before them have done (e.g. blind, deaf, learning disabled, epileptic and retarded) and to declare a war of research to find the causes and treatments for mental illnesses.

Each stricken family needs to be found as soon as possible in stage one, assured that they are not alone, that they did not cause the illness and that something can be done about it. This kind of emotional support and reassurance is being given today by some 270 local self-help groups in 47 of the 50 states. These groups have joined together to form The National Alliance for the Mentally Ill.

Eventually most families move to stage two -- accepting the illness and seeking to learn about it. Unlike other diseases where there is a medical consensus on treatments, the medical community offers several hotly contested treatment modes for mental illness. Therefore, families must learn about the disease of their family member to *make the decision on treatment mode* (e.g. psychoanalysis, neuroleptic medicines, diet, megavitamins, antallergy treatment, etc.). They need to educate themselves and hence they need guidance about which literature, lectures and counselling will best contribute to their education. The best source of such guidance comes from families who have already been through the experience. Mental illness is not a disease where the family can remain passive, content that the doctor knows best, because the family must decide which doctor to consult.

The need for self-education goes beyond the decision on treatment mode. For example, it includes education on commitment laws, taxes, selecting a psychiatrist, insurance, and governmental support programs, and finally, as the family progresses to stage three, there is a need to learn enough about the mental health system to begin to improve it. At this stage the self-help group offers a vehicle to channel the energies of family volunteer-advocates into those areas and activities where they can be most effective.

Education of Mentally Ill Adolescents

Families of all handicapped children have the opportunity to be part of the individualized education plan (iep). It is written into the law that they must be included in helping to plan for their child's education. Families of mentally ill adolescents have a great deal of knowledge about that child and they are needed to help in the plan. It has been an unfortunate part of the training of some of our professionals in the mental health arena to believe that the family is the cause of the schizophrenia or severe depression, the effect of which is to alienate the adolescent from the family. Oftimes, the family is the only support system the adolescent has and, by convincing him/her that the family is the enemy, the professionals destroy this important support.

Parents of mentally ill adolescents must be able to monitor the programs that their children are in. They must be able to tell whether a program is merely custodial, or if there is real growth possibility. Many of us with hindsight lament that our schools did not give our mentally ill adolescent a marketable skill while he/she was in high school: something he could turn to and do when his illness is in remission. Vocational education is paramount. Families must promote interagency collaboration. For example, they must insist that the Vocational Rehabilitation agency is working in high school to bridge that awful chasm that exists when school is out (the child reaches 18, or 22 and "ages out"). "Age out" or "transition out" means grows to the age when the P.L. 94-142 mandated educational program expires. There is literally nothing in the community for him or her to turn to -- no housing, no supportive day services, no job training, and no support for the family. Only abundant stigma.

NATIONAL ALLIANCE FOR THE MENTALLY ILL

The National Alliance for the Mentally Ill (NAMI) is a self-help movement of families, friends, and former mental patients that advocates for the chronically mentally ill, including research into the causes and treatment of mental illness and support services for mentally ill persons, and that provides information, education, and emotional support to families with a member afflicted with serious mental illness.

This self-help movement is the result of shared reactions to many problems. These include: (1) insufficient attention by mental health professionals to the chronically mentally ill; (2) fragmented and under-financed institutional and community-based treatment services that lack continuity of care; (3) uncoordinated national, state and local policies toward the mentally ill; (4) grossly inadequate funds for research despite the fact that mental illness hospitalizes more Americans and results in more long-term disability than any other illness; (5) discrimination against the chronically mentally ill by insurance companies, service providers, employers, and government; (6) lack of any concern for families of the mentally ill who feel isolated, stigmatized, and do not know how to deal with their problems; and, (7) destructive attention by some providers who teach that families caused the illness.

The families in Alliance perform a role for the chronically mentally ill comparable to that played by other successful national health organizations such as those serving the mentally retarded, the autistic, and other disabilities. NAMI is unique and different from other organizations that advocate for the mentally ill in that it is a self-help movement composed primarily of relatives of persons with severe mental illnesses, and that it focuses on those disabled by chronic mental illness as distinct from painful but not disabling problems in living.

The Purposes and Goals of the Alliance

- Reassure the afflicted families that they are not alone, giving them emotional support, and giving them the basic education on mental illnesses they will need to cope with the problem and to deal with a psychiatric profession uncertain of causes and of treatments for the illnesses;

- Advocate for research in the basic sciences to prevent, ameliorate, and eradicate serious mental illnesses;
- Advocate for quality institutional and community-based services for the mentally ill including appropriate residential, vocational, rehabilitation, employment and income maintenance programs;
- Monitor and comment on the performance of providers both private and public;
- Influence mental health professional training, practices, and attitudes to focus on the needs of the chronically mentally ill, and to encourage collaborative working relationships with their family members;
- Change the delivery system to better identify and serve the chronically mentally ill, to provide continuity of care among a broad range of services, and to deliver effective, accountable and responsive services;
- Foster public education and information about serious mental illnesses, to remove the stigma of mental illness and replace it with understanding and sympathetic support; and,
- Advocate for new and remedial legislation to better serve the mentally ill.

Programs Offered:

1. Emotional Support Services -- A severe mental illness causes major upheavals in family life, threatens its stability and results in severe psychological and physical stress. Families are not prepared to deal with the extraordinary demands of caring for a family member with a major mental illness. Faced with these difficulties, local affiliates devote considerable attention to providing emotional support and practical advice to their peers through emotional support sessions (sometimes called "sharing/caring" sessions). For families there is no substitute for being able to share feelings and experiences with those in the same situation. Families no longer feel so alone -- they find hope, greater perspective, and new ideas for handling problems.

Emotional support sessions are educational rather than psychotherapeutic with alternate management approaches stressed. Emphasis is placed on coping techniques and competence models based on the knowledge and expertise gained by members in their struggles to cope successfully with the mental illness of their relatives.

Emotional support sessions occur once a month or more often in small group meetings usually held in family homes. In addition, members provide mutual support through telephone and other contacts especially in crisis periods.

2. Family Education -- Little information is given to family caregivers by the psychiatric world. Families are left in the dark about the nature of the mental illness, the treatment being used, what to expect from treatment including the various medications and their side-effects, how to manage disturbed behavior in the home, and necessary community resources and income maintenance programs for the mentally disabled.

To meet families' needs for such information, affiliates hold educational meetings once a month, which mental health professionals, researchers, and community resource people are invited to address. Statewide associations hold similar educational overnight or two-day seminars, as does NAMI at its annual three-day national convention. The meetings not only educate members but also the invited experts learn much in the give and take discussions.

Subjects discussed include biochemical origins of serious mental illnesses and genetic predispositions that research findings now verify, helpful family interventions, information about various neuroleptic and anti-depression drugs, model community programs, commitment laws, social security disability programs, guardianship and trusteeship arrangements and other matters of concern to families.

Most affiliates issue newsletters which provide helpful educational information and summaries of educational meetings, and alert members about local lectures and events. NAMI's bi-monthly newsletter to all members is educational in content. It is supplemented with a bi-monthly letter to each affiliate that deals with conceptual issues, suggested strategies, and legislative information. Affiliates usually maintain lending libraries with helpful books and articles, and NAMI has a "Reading and Resource List" and recommended readings for members.

In the past two or three years there have been several new books, monographs, and magazine articles written for families by family members or by sympathetic professionals citing NAMI and its affiliates as helpful resources. Additionally, NAMI is issuing guides and informational pieces for members. (Family member publications include: Families in Pain: Children, Siblings, Spouses, and Parents Speak Out by Phyllis Vine, Pantheon, 1982; Coping With Schizophrenia: A Survival Manual by Mona Wasow, Science and Behavior, 1982; and Coping With Mental Illness in the Family: The Family Manual by Agnes Hatfield, University of Maryland, 1984.)

3. Mental Health Professional Education -- The growth of NAMI reflects in part the alienation from the mental health profession felt by many families. A schism generally has existed between professionals and families growing out of the now increasingly outdated view that families cause chronic mental illnesses, and the lack of understanding by professionals of what families experience in dealing with mental illness in the home.

Families of the mentally ill suffer from the same anxieties, grief, fear, pain and frustration experienced by those with a terminally ill family member or one severely physically disabled or retarded. Families of the mentally ill do not feel they caused their child's illness any more than parents cause leukemia or Down's Syndrome. They resent professionals who view them as deficient "patients" when they turn to professionals for help. They criticize the lack of tangible and concrete help from professionals and the lack of information sharing which is often excused on the grounds that the "confidential" nature of the patient-doctor relationship prevents communication between therapist and family even though it is manifest that the family is the primary care giver.

NAMI has an active Curriculum and Training Committee whose purpose is to influence the training of mental health professionals, to educate and increase professionals' understanding of the experience of mental illness as it is known by the family in its day to day association with a patient in the natural setting of the home. Most Committee members are professionals in mental health or education as well as relatives of mentally ill persons and have access to training centers and professional meetings. The members make presentations at professional meetings, write journal articles for professional journals and collaborate with non-family professionals on presentations and articles to mental health audiences and readers.

Other educational efforts with professionals occur during the annual conventions which are usually held with the participation of the departments of psychiatry and other graduate department personnel of universities. NAMI invites professionals to attend its conference, and is invited to attend their professional annual meetings. NAMI's President, who has non-mental health research experience, serves on the NIMH Advisory Council that advises NIMH on mental health research directions and projects.

NAMI is a member of The Mental Health Liaison Group of national mental health organizations, and is a founding member of the Council for Understanding Mental Illness (CUMI) that deals with modifying anti-stigma attitudes toward the mentally ill -- both groups that are predominantly professional in makeup. Professional associations are now inviting family members to participate on committees. The latest example is the American Psychiatric Association and NAMI's agreement for a joint committee to publish a handbook on psychotropic medication for use of patients and families. These endeavors improve awareness by professionals of the role of families which should lead to better collaboration between providers and families on behalf of mentally ill persons.

4. Public Education -- NAMI members increasingly are "coming out of the closets". Members reach the public with their accounts of their experiences and of affiliates' activities through TV, newspaper and radio exposure. Occasionally the mentally ill relative is also included and interviewed.

NAMI has prepared an Anti-Stigma Handbook to guide affiliates in working with local media and civic and community groups. NAMI has in preparation a series of Publid Service Announcements, the first two of which will be viewed in March 1984 through national TV channels, and with the involvement of affiliates, through local channels.

The Phil Donahue Program presented a program on schizophrenia in July 1983 that subsequently was syndicated to over 500 stations in the U.S. Dr. E. Fuller Torrey, a researcher and author of Surviving Schizophrenia: A Family Manual, together with family members from the Illinois AMI, and patients discussed schizophrenia and NAMI. The program resulted immediately in over 7,000 calls to the National Office and thousands of calls to affiliates. This program is re-shown from time to time which always produces a flood of calls.

5. Advocacy for Research, Supportive Programs and Legislation -- Mental illness is a disorder of such catastrophic proportions that no patient and few families can by themselves muster the resources necessary for even minimal care. Unfortunately, appropriate care for the mentally ill has never been a priority wtih either federal, state or local governements. In large part this is because there has been no vigorous constituency calling attention to the need. The National Alliance and its many affiliates hope to persuade society that it has prime responsibility to care for persons with this affliction. To that end, members are learning the intricacies of the legislative process and bringing pressure to bear on local, state, and national levels of government. Occasionally, the courts are used as a source of remedy.

The goals of advocacy are many. There is a dire need for supervised housing. At present 50-60% of patients return from hospitals to live with families. Only a small percentage of persons in the community have programs for social rehabilitation or vocational training. There is a movement across the country to change state laws so as to make it difficult to plead "Not Guilty by Reason of Insanity". Budgets for research are infinitesimal when the magnitude of the problem is considered. Publicly supported and even private hospitals often do not meet standards for optimum care. Families in the United States are deeply concerned about these matters, but they are also fully aware that none of these battles will be won easily -- especially in this time of fiscal restraint.

6. Monitoring Providers' Services -- An area of great activity for many affiliates is to follow the work of mental health providers and analyze it and comment on it, offering praise when that is warranted and criticism whenever it appears that will be helpful. The experience of many AMI members is that providers appreciate getting feedback on their work. Monitoring includes both public and private clinics and hospitals. Many affiliates keep a list of psychiatrists that are rated high by their members and refer callers to those families to guide them in selecting therapists.

7. Research -- The National AMI Research Committee reviews current research developments and applications and recommends on public policy priorities in research on mental illness to the Board, affiliates, and the Federal Government. National AMI encourages scientists to utilize the resources of family members for research purposes to better understand genetic, epidemiologic and other variables involved in severe mental illnesses.

Members are urged to participate in research endeavors that will further scientific knowledge of mental illness. This includes donating the brain of ill family members following death to established brain tissue resource centers, and collaborating with research in university settings. One such effort included the study "Families as a Central Resource in the Rehabilitation of the Severely Psychiatrically Disabled", conducted by Boston Unviersity's Center for Rehabilitation Research and Training in Mental Health. Another study was the "Patients' Rights Policy Research Project" through the Human Interaction Resources Institute, Los Angeles, California.

The Research Committee is developing plans for "Young Scientist Awards" to foster their involvement in research activities on mental illness. The committee is also exploring the possibility of a national invitational workshop of researchers to review major research discoveries of the past decade, and its significance in the 1980s.

8. Information and Referral (I&R)-- This nationwide service provided through the National Office and affiliates is available to anyone seeking help, guidance or information regarding a mental illness. Telephone and mail inquiries range from securing relevant services and facilites, information about mental illnesses, medication, research, obtaining social security benefits, to commitment procedures, service standards, and forming mutual support groups.

Oftentimes, these calls are the first contact on the part of a family member or individual reaching out for help with the agonies of a serious mental illness. These persons usually share feelings of despair and isolation, inability to cope with the overwhelming problems involved, and are relieved to learn of the existence and availability of a national network of mutual support affiliates and fmailies with whom they may comfortabley share their experiences and from whom they may learn.

National AMI maintains a "Directory of Affiliates", a listing of affiliate contact I&R persons with their addresses and phone numbers. These contact persons are available for immediate personal support to callers at times of crisis, and are knowledgeable on local resources and facilities.

The I&R National Office and local services are available at no cost. Individuals may call the National Office "collect" to secure the service. Follow-up to inquirers may include repeated telephone contacts, mailing of helpful articles and referral to local family support affiliates.

A recent Phil Donahue program (July 20, 1983) on schizophrenia with Dr. E. Fuller Torrey and family members from the Illinois AMI provided the National AMI telephone number as a "hot line". The result is described above under "Public Education".

9. Lost-Person Networking -- If a mentally ill relative leaves the area, as so many do, to drift around the country or to relocate to another locale, National AMI through its affiliate network provides support points that may be contacted in other cities. National AMI affiliates and members have searched hospitals, flop houses, soup-lines and succeeded in locating mentally ill individuals. They provide help, arrange for an appropriate plan and services for the individual, and sometimes will serve as family substitutes providing guidance and supervision. the network keeps the anxious family informed of developments.

10. Community Services -- Many affiliates have stimulated and developed an array of community support services, or offer such services through spin-off non-profit corporations or through the affiliate itself for chronically mentally ill persons. Such community services include residentail, pre-vocational, employment, crisis services, socialization and recreational services, and other services to support the optimum functioning of mentally ill persons in the community.

Some affiliates, concerned with the large number of mentally ill persons inappropriately placed in jails, or homeless, are developing special projects to divert and provide alternatives for such individuals in need.

In summary, mental illnesses are catastrophic diseases that typically strike in adolescence or early adulthood. The role of families is (1) as primary care giver especially during adolescence but often lasting as long as the parents last; (2) to reassure and give emotional support to other families becoming involved in the problem; (3) to educate themselves because, perforce, the family must typically make the choice of provider in a profession that has not developed a consensus as to cause or treatment and (4) to organize themselves as other handicapped groups have done before to build a social system that makes a fair place for their loved ones; and (5) to demand that a war of research be declared to find the causes and treatments of mental illnesses.

Senator **Denton**. Thank you very much, Mrs. Howe. I have great admiration for the work you and your organization are doing.

Since your statements are somewhat more allied than usual, I would ask that Dr. Wilmarth—who I am glad to see again—would give his statement, and then I will ask questions of you jointly.

Dr. **Wilmarth**. Thank you, Senator.

I am Dr. Richard Wilmarth, a certified clinical mental health counselor. I am also president-elect of the American Mental Health Counselors' Association, which is a division of the American Association for Counseling and Development.

I am also a licensed professional counselor in Alabama, where I am director of the Opelika Counseling Center.

Senator, I am deeply honored to come before you today as a representative of the American Association for Counseling Development and its more than 41,000 professional counselors who work with children and families in many settings, such as community mental health centers, elementary and secondary schools, colleges, rehabilitation centers, and private practice.

Senator, once again, I bring to you greetings from your friends and neighbors in Alabama, who have personally voiced to me their support of your involvement in and concern for improving the overall family environment in our society.

The concern of your hearings, "Parental Involvement With Their Adolescents in Crisis," is an extremely important one, and one that is well appreciated by all counselors who respond to a multitude of youthful crises, whether they be difficulties in the home, with parents or siblings, problems of drug abuse or alcohol abuse, problems within the school or emotional problems fostered, in many cases, by an insecure and often hostile home environment.

In many cases, the involvement of the parent is an important ingredient in attempting to solve these problems. In my own practice in Alabama, I can think of many examples of the importance of having total family involvement in working with the mental health problems of the adolescents that I work with.

As a matter of fact, I personally encourage and almost insist when I work with an adolescent that his parents, be they a single parent or both parents, become actively involved in the counseling process. I have noticed in my practice when I work with adolescents, when the parents refuse to enter into the counseling process and work as a team when their child has a problem, this lack of involvement on the part of the parents also impedes, if not actually creates a negative effect, on the therapeutic process.

Now, these parents really do not need to be criticized. It is my belief that parents need help; they need support. I believe most of the parents are truly seeking answers. In some cases, they are facing crises of their own: Unemployment, mental illness, marital stress, and so forth. In other cases, they are simply unable to recognize that their child has a problem—or, if they do recognize that the child has a problem, oftentimes they lack the sufficient parenting skills to respond to this problem in an appropriate way.

I would like to interject at this point that as I was reading the Washington Post on the plane up here this morning, I happened to notice an article that indicated that the Hinkleys, which I am sure we are all aware of that case, have left their home in Denver, CO, and have moved to Washington and plan to spend 6 months here to participate in weekly family therapy with their son.

I think significantly, the Association for Counseling and Development——

Senator **Denton**. Dr. Wilmarth, I cannot help but interject that I think Mr. Hinkley is going to form a foundation, because one of the finest young men on my staff is leaving me to go to work for him in that work.

Dr. **Wilmarth**. That is correct.

Significantly, the Association for Counseling and Development and its divisions have emphasized parental involvement not only as a way to ameliorate possible ranges of problems apt to befall an adolescent, but also, they are involved with preventive measures.

In earlier testimony that we have heard today, Dr. Strommen indicated that parental training was one area in which Government should become involved. I wish to echo this, and I would offer to you and suggest to you that professional counselors in our association are in a position to provide a great deal of assistance in this training.

The following are but a few examples of the action that our association and its divisions have taken over the years. In 1960, the National Vocational Guidance Association, which is a division of the American Association for Counseling and Development, reprinted a guidance pamphlet from the Minnesota Department of Education, entitled, "Parents and the Counselor." This document received widespread distribution, and its contents are justly applicable today. It basically points up the complementary roles of parents and counselors as they attempt to affect the lives of the youth in our society.

In 1976, the American School Counselor Association, also a division of the Association for Counseling and Development, published a special issue of their journal, entitled, "Parents, Counseling and Communication." The editor of that issue noted that, "Working directly with parents has become an important emphasis for the counselor to consider." This popular publication suggested methods of dealing more directly with parents and the influence of the family dynamics on the growth of the child. The literature in the mental health field and the findings and methodologies regarding the parents' role in counseling with their adolescents is numerous.

A few of these titles indicate the range of interest to the counselor. For example: "Family Counseling with Illicit Drug Users," which was an article appearing in the Journal of Offender Counseling: "Adolescent Substance Abuse: Working with the Total Family," appearing in the School Counselor Journal; also, "A Family Assessment Process for Community Mental Health Clinics," appearing in the American Mental Health Counselors' Association Journal; also, "Family Counseling is the Key to Successful Alternative School Programs for Alienated Youth," appearing in the School Counselor Journal.

While the literature on the issues is substantial, much needs to be done to improve counseling programs to better assist families in coping with our increasingly complex society. We would like to suggest two directions which would contribute to increased parent-child communication.

First, a better understanding of the role and function of the counseling process; and second, specialized training in family counseling for counseling practitioners. Our rationale for each suggestion is the general public and, in particular, parents and adolescents, need to understand the contribution counseling can make in their family relationships. Counseling services facilitate parents' and youth's effort to communicate and work together effectively. It is particularly important that parents and youth have a positive attitude toward counseling. When they understand that they can talk together about difficult problems with a counselor to facilitate their communication and help plan appropriate steps, they are actually more willing to work together.

Orientation programs which describe the role of the counselor in schools, community agencies, mental health and private practice settings must be encouraged and supported.

Our second suggestion is to provide additional training to counselors at the preservice and inservice levels, emphasizing the role of parents in the counseling process, strategies for involving them effectively, and methods of counseling the families.

Many counselors have been trained in individual and group counseling processes, but may have had little exposure to family counseling approaches. They may be reluctant to involve parents or lack the skills to make counseling relevant and effective for parents and their adolescent children. Increasing the parents' understanding and skills will contribute to more productive parental involvement, thereby, I believe, enhancing the positive outcomes of counseling.

We believe that counselors should encourage and assist youth in involving their parents in the counseling process when they face an individual problem such as drug dependency, alcohol abuse, mental illness, or early sexual intercourse or unplanned pregnancy. Many are reluctant to tell their parents about their problems, but are willing to talk with a counselor. Such adult assistance, even if it is not first provided by a parent, can be crucial. Counselors then are able to persuade adolescents to inform their parents and involve them in solving the problems they face, thus, in many cases, encouraging but not requiring parental involvement, encourages youth to seek help from an adult trained to assist them with their problems, and also, second, provide the support to help them talk to their parents.

The two steps which the American Association of Counseling Development proposes—greater public awareness of the importance of counseling and enhanced skills by counselors in dealing with parents and their children—I believe will contribute to better family communication and more effective use of counseling to solve the complex problems that our youth are facing today.

Senator Denton, the American Association for Counseling and Development and myself personally have been pleased that we have been asked to speak today on this important issue, and we look forward to assisting you and the Congress in developing programs and services which better address the multitude of personal and social concerns which our families must face.

I will be pleased to answer any questions you may have.

Senator DENTON. Thank you very much.

I will address the first question to Mrs. Howe, and again, remind you that irrespective of the person to whom the question is addressed, if you would care to make any comments, please do.

What laws, Mrs. Howe, do you think need to be altered that might now tend to prevent the inclusion of the family in the treatment of adolescents, or to include them not enough? What changes can we make, should we make?

Mrs. HOWE. I believe that there needs to be much more funding for many of the support programs in the community—and I am thinking in terms of young adults, who are ready to be independent. The parents for reasons of biology, are not going to be able to take care of them forever, and therefore society should establish a network of facilities to provide this care.

As far as involving the family, I think that if, indeed, we have much more education about mental illness, if we help the whole world know that it is not something that was caused by bad families, this will be very helpful to the families, so I think if we just have more education, more good public relations about mental illness, more money, as I said, for the community support programs, and certainly more money from the Federal Government in research programs—that is tremendously necessary, because it is very underfunded right now.

Senator DENTON. Well, of the money that the Federal Government is feeding into it, would you say it is apportioned properly with respect to allocation, amongst such needs as research, or training of parents in how to cope? Do you have any feel for that?

Mrs. HOWE. I do not think they are spending any money on helping parents become trained. That is why the National Alliance for the Mentally Ill was created. As I said, we were either ignored or we were blamed, and now we are being "treated." If you look in the literature at the kinds of education given families who have another kind of a catastrophic illness, say, multiple sclerosis—it is entirely different, the tone of it is different, more supportive, and less blaming. And I think families of mentally ill persons deserve a kind of education similar to that given families with other catastrophic illnesses.

Senator DENTON. Well, I have had the feeling that, while I support the Federal, State, and local governments' establishment of their own set of professional counselors and so forth, bureaucracies to deal with the problem—and I do not use that term in denegration—I also have the feeling that in these social problems which have accelerated, have intensified, such as the one with which we are now dealing, that there is a need for a shift in emphasis which would involve the Government considering more financial help to agencies which are principally private initiative, volunteer, and if they are too amateurish in the view of the medical or the professional professionals, then let the Government attach those professionals to those volunteer units, because they care. They are not subject to Parkinson's Law. They are not trying to grow in size. They are not trying to do the things that government bureaucracies tend to be tempted to do.

That is just an observation I will make. But I wonder, Dr. Wilmarth, if you see any efficacy to that. If you do, you are a remarkable man, because you are working for a State as a counselor. But do you see what I am getting at?

Dr. **Wilmarth**. Senator, what was your last statement—that I am working for——

Senator **Denton**. Well, you are getting Federal funding for yours.

Dr. **Wilmarth**. Well, just for the record, I am in private practice, so all my money comes from my work.

Senator **Denton**. Well, give me the degree to which Government does fund for the program—and this is not one of my areas of normal expertise—goes into research, but not to fund the treatment of the kind you have been talking about—not yours, at all?

Mrs. **Howe**. Well, I think maybe we need to differentiate. I think probably what he is talking about more are problems in living, the kinds of things that families are faced with, like drug abuse. I am talking about severe mental illness. I think it needs to be separated out. Unfortunately, we do not have satisfactory physical markers for mental illnesses yet, but they are working on it at NIMH. Certainly, some of the problems are the same.

Senator **Denton**. And certainly, you are not capable of research; but you are capable of dealing with the problem more efficaciously in the community, among families, kind of gather them together and synergistically help in respect to some of these problems.

Mrs. **Howe**. Right. That is one of the things we do as families. We help each other learn about the illness. And I think we might not have had to do this if there had been people who could say, "Look, I do not know anything about it." We just do not know.

Senator **Denton**. There is a difference between—and I do not know whether I can get this across, and I do not want to waste your time on it now—between the Government creating departments, bureaucracies which will totally handle a problem, a social problem, resulting in what Dr. Thomas Sowell, who I quote frequently, of Stanford University, a Ph.D., happens to be black, resulting in this. He says if one-third of the money normally appropriated for the poor were to actually reach the poor, we would have no one left in poverty. Now, there is something wrong with the system when that is a fact, and it is a fact in many of these other areas in which we are dealing, in which we have tremendous bureaucracies which somehow are inefficient in dealing with the problem. It seems to me that there could profitably be a shift in an overall welfare program—which is too politically sensitive to talk about this year—toward Government assistance financially, to volunteer organizations. These groups, after examination by the appropriately qualified authorities, are deemed to be efficient in their work, and are just paid for their expenses—not paid wages. These are people who are already willing to do the work free and are dedicated to it often because of familial involvement or conscientious involvement. There is a difference between that and setting up a Government bureaucracy to do it. It seems to me that the latter has been more often the case, and that is the observation I am trying to make.

Mrs. **Howe**. Well, I see what you are saying. But I do think that the Government sometimes has led the way—I am thinking in terms of the community support program, a very small program in NIMH, which has really led the way. They have not given direct services; they have served as a catalyst in all of our States to show the kind of support system that is necessary for the mentally ill after they leave the family. And I really feel that in some cases, Government can lead the way.

However, I do agree with you, Senator Denton, that the job—for example housing or low stress employment for the mentally ill probably can be done much better by private-nonprofit groups than directly by Government. And in the case of non-profit groups, Government financial support should be given with much less paperwork. After all, such groups are not trying to make money off the Government. Of course the Government will have to finance the community support systems since nonprofits have no money of their own.

Senator **Denton**. Oh, there is no question but that there is a place for Government expenditure. But we are spending twice in the social welfare field what we are spending for defense. We are talking about cutting defense—fine—to balance the budget. I will defer to everyone's right to have their view. In Kennedy's time, we were paying half as much for social programs as we were for defense. We probably had one-fifth the defense problem we have today in terms of our vital interests, say, in the Mideast and Latin America. This is not to gainsay the fact that we also have a much greater degree of social problems. But the causes of those problems are what we have to find, because—and I agree with you about the research—because just to feed the end of the pipe is not good enough. We have got to get up in that earlier part of the pipe and input some things that make what comes out more pure—that applies to all four of the fields we are discussing this morning, I think.

Is there sufficient recognition in the field, on the part of the Government, that the family needs to be involved in both of your opinions, or do you see any manifestation by which you could make such a judgment?

The subject of this hearing is family involvement. You are giving the opinion that the family needs to be involved. Is the Government, from your perspective, sufficiently aware of that need?

Mrs. **Howe**. I am not sure that they are. Governments tend to be confused on the issue of how to involve families many Government agencies, tend to accept the popular view that families caused the problems of children and therefore should be excluded or reformed. In fact families have much to offer in planning a program to help teach the mentally ill child. That is an appropriate and constructive way to involve them rather than excluding or accusing them. Basically it is a question of educating the ranks of Government—and, yes, the public—about the facts of mental illness. I think this forum today, is an example of how Government can help. I hope some people learn more about mental illness. I congradulate this committee. Parts of the executive branch are also helpful, for example it is getting parents more and more involved in advisory councils. I think that is very important that the family be recognized in many ways and that Government understand that we have something very positive to contribute.

Dr. **Wilmarth**. I would support the statement that families certainly need to be involved. I am not so sure that they are being encouraged to be involved. I cannot help but feel, also, that we are talking about problems and the way the Government chooses to deal with those problems. As you point out, they choose to identify a specific problem and establish an agency to deal with that problem, and I sometimes feel we overlook the basic reality about where the problems came from. And it is my feeling that if we could divert some of the moneys that we are putting to support the bureaucracies into programs that would truly look at such issues as parental education, training, subsidizing self-help groups, where there is a great deal of support, interchange, communication going on——

Senator **Denton**. Subsidizing their expenses where they do not even ask for a salary.

Dr. **Wilmarth** [continuing]. Right—where this would happen, then we might see less of a need for the bureaucracy, simply because the problems become addressed directly and are ameliorated.

So I would hope that one of the things that comes out of your hearings, Senator Denton, is really the importance of providing some governmental direction and support, and encourage parental education. You know, we license everything in this country but parents, and we send everybody for training in this country to do things, but we never really encourage training the very heart of our country, which is the parents.

Senator **Denton**. Well, I am not going to be oversimplistic in approaching the problem. I admitted at the outset that they are extremely complex. I doubt that many feel the sense of that complexity more than I in dealing with these problems. I have had to deal with them in terms of this, with prayer in schools; they are all very complex, and I am not of the opinion that I am omniscient, or that I have learned a tenth of what I must about them. But I have a feeling that there is a long way between the President's policy statement on how he, as the head of our Government, looks at the importance of families, and how our Government per se, actually is dealing with families, and I intend to try to help that situation as a general intent.

Thank you very much for your testimony this morning.

Our next panel will discuss the importance of parental involvement in adolescent sexuality education and treatment programs.

Our first witness, Dr. Frank Furstenberg, is professor of sociology at the University of Pennsylvania. He will discuss family communication in the field of adolescent sexuality. He is also a board member of the Alan Gutmacher Institute, a research arm for the Planned Parenthood Federation of America.

Following him, Dr. Stephen Potter will speak. Mr. Potter is cofounder of Teen-Aid, Inc., which is now active in six States. He will discuss Teen-Aid's efforts to be a community resource in support of traditional family values, through the provision of sex education curricula and other services.

Dr. George Rekers is a professor with the Department of Family and Child Development at Kansas State University. He is a leader in the field of family psychology and will discuss the wider ramifications of parental involvement in adolescent sexuality programs.

Dr. Bird was the initial consultant to the Kennedy Foundation's "Community of Caring" project, which presents a curriculum for comprehensive adolescent pregnancy problems.

Welcome to all four of you gentlemen, and I will ask you, Dr. Furstenberg, to begin.

STATEMENT OF DR. FRANK F. FURSTENBERG, JR., PROFESSOR, DEPARTMENT OF SOCIOLOGY, UNIVERSITY OF PENNSYLVANIA; STEPHEN C. POTTER, COFOUNDER, TEEN-AID, INC.; DR. GEORGE A. REKERS, PROFESSOR OF FAMILY AND CHILD DEVELOPMENT, KANSAS STATE UNIVERSITY, AND DR. LEWIS P. BIRD, INITIAL CONSULTANT TO KENNEDY FOUNDATION'S "COMMUNITY OF CARING" PROJECT

Dr. Furstenberg. Thank you very much, Mr. Chairman, for this opportunity. I will try to make a brief statement and then have some material for the record.

It is easy to forget that adolescents were not served by family planning programs until quite recently. In 1965, when I began my research on the causes and consequences of teenage childbearing, unmarried teenagers were almost universally denied access to family planning programs, even when they had demonstrated a need for services by becoming pregnant. At that time, there was not even the policy that came into existence later, of the ticket admission, which was pregnancy. No one was served who was below the age of 18.

Rates of teenage child-bearing have been rising since the end of World War II, but adolescent fertility was not generally defined as a social problem until childbearing among older women began to decline, while rates of teenage pregnancy and child-bearing remained relatively high.

Moreover, in the 1960's, nonmarital fertility among teens began to rise. In 1965, over half of all births to teenagers were premaritally conceived, suggesting that at least a quarter of all adolescents were sexually active at that time.

In an effort to curb rising rates of teenage pregnancy and childbearing, family planning services were gradually extended to teenagers.

From the early seventies, a majority of Americans said that they favored the provision of birth control to unmarried adolescents who requested it. Thus, the extension of family planning services to teenagers grew out of a popular demand to combat a widely-perceived public health problem. Yet there has been a lingering apprehension, and I think it is the occasion of these hearings that expresses that, that the creation of family planning programs has ultimately weakened the will of parents to take measures to prevent teenage pregnancy and childbearing. Let us look at the evidence of how family planning programs currently deal with parents, and what, if anything, they do to promote family involvement. And I think we are in a somewhat novel area, so I am talking about the state of the art in the early eighties, but it is constantly changing.

The information on which I will report comes from a survey of family planning providers undertaken in 1981, to measure the extent to which family planning programs make deliberate efforts to involve parents in their activities. The results are encouraging, and clearly contradict the impression that family planning clinics systematically seek to build a barrier between parents and their teenage children. The vast majority of programs are making an effort to serve parents and have done so for a number of years.

About 6 out of 10 agencies provide family counseling, and a significant proportion sponsor parent discussion groups, work with parent advisory committees, and hold trading workshops to help parents improve their skills as sex educators. Those agencies which are reaching out to parents attract a substantial number of parents. About half of those with parent participation programs, of those with high parent participation programs, serve about 25 parents for every teenage client—that is, they are pulling in a good portion of parents.

The strongest predictor of parent-oriented programs was the presence of a consumer advisory board—that is, participation by the local community. Mandatory parental notification procedures by contrast, do not appear to promote parental involvement. Agencies with such strictures actually have lower levels of parent participation. Let me say a few words now about the possibility of promoting greater family communication and family planning programs, because that is the core of these hearings. With a 1979 grant from the Office of Family Planning, I worked with the Family Planning Council of Southeastern Pennsylvania on an experimental program known as the Kinship Project, to encourage open communication between teenagers seeking contraceptive services and their parents. With the teenagers' full knowledge and consent, trained family planning counselors attempted to approach the families, usually through the teenager herself, and to discuss ways of assisting the parent to help the adolescent to avoid an unwanted pregnancy.

The program was carefully evaluated to measure the success of reaching family members and to assess the impact of family support on pregnancy prevention. We discovered that most teenagers inform their parents voluntarily, either shortly before or just after coming to a family planning clinic.

Efforts to promote family involvement had little effect on getting teenagers to discuss their sexual activity with their parents and no effect on their sexual behavior or contraceptive practices. Indeed, it proved to be extremely difficult to interest parents or teenagers in the family planning clinics in joint discussions.

I believe that it is highly desirable to enhance parents' skills in communicating values and information to their children. But our data suggest that parents cannot always be the sole or even the primary source of sexual socialization.

In a recent national survey of adolescents conducted in 1981, just about half of all teenagers said that they usually could talk to either or both of their parents about sex. Interestingly, children are noticably less likely to be able to discuss sexual matters as they move from early to middle adolescence. About three-fifths of the younger adolescents could communicate about sex or felt able to communicate easily about sex to their parents, compared to less than half of the older adolescents—that is, adolescents in their middle teens. Overall, teenagers who communicated more comfortably with their parents about sex were no less likely to have had sexual intercourse. Thus, our findings seemed to suggest that opening up discussion within the family is likely to have a very modest impact on teen sexual behavior and pregnancy reduction, if it has any effect at all.

Nevertheless, I endorse the idea of promoting greater parental participation in pregnancy prevention programs. Parents need information, and they can often acquire greater skills in communicating with their adolescents.

I strongly oppose efforts to mandate uniform procedures for obtaining parently involvement, because I think such efforts are likely to be destructive and counterproductive. Rather than resort to rigid bureaucratic solutions, such as mandatory parently consent or notification, we must try to stimulate innovative programs to enhance parental participation.

Congress should provide additional funding to promote experiments to achieve this objective, and these experiments ought to be carefully evaluated. Such funding would be consistent with the spirit of the amendment in the title X legislation requiring clinics to encourage family participation. Our research suggests that the vast majority of family planning providers support greater parental involvement, but they are not comfortable with any approach that slavishly applies a simple formula to all families.

The reality is that families are diverse, and programs to meet the needs of families must be similarly diverse.

Thank you, Mr. Chairman.

Senator DENTON. Thank you, Dr. Furstenberg.

[The prepared statement of Dr. Furstenberg follows:]

TESTIMONY OF

FRANK F. FURSTENBERG, JR.

Mr. Chairman and Members of the Subcommittee:

I am Frank F. Furstenberg, Jr., Professor of Sociology at the University of Pennsylvania. For almost two decades I have studied the causes and consequences of adolescent pregnancy, with a particular interest in its implications for the family. My publications include two books on adolescent fertility, *Unplanned Parenthood* and *Teenage Sexuality, Pregnancy and Childbearing*. I have also written numerous articles and papers on adolescent pregnancy.

Mr. Chairman, I appreciate the opportunity to be here today and commend the subcommittee for considering the important and complex question of the role of the family in adolescent sexual behavior and pregnancy.

For decades, young people have been sexually active outside marriage and have become pregnant. In the 1950s early marriage, adoption, and illegal abortion masked the number of premarital pregnancies among adolescents. Today, young women who become pregnant before marriage are not as likely to resort to any of these "solutions." Consequently, teenage sexual activity and pregnancy are far more visible than they were a generation ago and are made even more so by the availability of national health statistics and social surveys. What was once discretely concealed is now openly revealed.

The heightened visibility of teenage sexuality, pregnancy, and childbearing generated much interest in preventive policies and services in the 1970s. Congress' decision to make family planning services available to teenagers with federal funds has met with some success in limiting the increase in teenage pregnancies. However, since teenagers are often less effective users of contraception than older women there has been considerable interest in exploring measures that might enhance teenage contraceptive use.

In light of a number of studies — including one of my own — that indicated that teenagers used contraception more effectively when their parents knew they were sexually active, some experts suggested that one avenue to increasing contraceptive practice was to enhance communication between adolescents and their parents. In the past several years, then, a number of proposals have been put forward to promote greater communication between adolescents and their parents. These have ranged from voluntary programs of public education and family counseling to the recent Department of Health and Human Services' regulation -- struck down by the courts -- to mandate parental notification when teenagers seek contraception. The controversy over the latter policy exposed a number of practical problems to involving parents as a matter of routine and it also revealed that our empirical research on the relationship between family communication and contraceptive practice is extremely thin.

With a 1979 grant from the Office of Family Planning in the Department of Health and Human Services, I worked with the Family Planning Council of Southeastern Pennsylvania on an experimental project, which came to be known as the Kinship Project. It was designed to promote family involvement with teenagers seeking contraceptive services. Its aim was to build family support for using birth control by fostering more open communication about sexuality between the adolescent and some designated family member or members, usually the mother. With the teenager's full knowledge and consent, trained family planning counselors attempted to approach the family, usually through the teenager herself, and to discuss ways of assisting the adolescent to prevent an unwanted pregnancy. The program was designed to permit a careful evaluation of the success in reaching family members and the impact of family support on contraceptive use over a 15 month period. The study, by the way, involved over 400 teenagers under the age of 18 and the participants were fairly typical of teenage clinic attenders in the Philadelphia area. The sample was evenly divided between blacks and whites, most teens were 16 or 17 years old, six out of seven were nonvirgins and three out of 10 had already been pregnant. It was, in fact, the first large-scale study designed specifically to measure the effects of family communication.

We found that, even though more than four in 10 of the teenagers in our sample said, at the time of the first interview, that their mother was aware of their visit to the clinic, most of them had rather limited communication with their mothers on these issues. While most of them reported having fairly good relations with their mothers, they were reticent about broaching sexual topics. Only a little over a third indicated that they had been able to discuss sex and birth control with their mothers. Over time, the proportion of teens who said their mothers knew about the clinic visit rose -- to almost three-quarters at the time of the 15 month follow-up interview. However, this did not signal enhanced family communication. The number of teens who reported discussions about sex and birth control remained virtually unchanged over time. Moreover, even among the young women whose mothers knew they were using contraception, more than half said they felt uncomfortable talking to their mothers about birth control. Only 16 percent reported that they felt comfortable. Significantly, however, four out of five teenagers who provided information on their mothers' reaction to their use of contraception reported that the mothers approved of their visit to the family planning clinic.

Even when discussions do occur in the home, they seem to contribute very little if at all to the adolescent's ability to practice contraception effectively, nor do they constrain teenagers' sexual activity. Using a variety of stringent measures, we looked for evidence that communication with mothers influenced the patterns of birth control use or return to the family planning clinic. We found that after 15 months, 43 percent of the adolescents had used contraception consistently (with no lapses), 23 percent used it most of the time and 34 percent were ineffective users. There was no significant link between family communication and contraceptive use, however. Even when demographic differences within the sample were held constant and when changes in patterns of communication and the extent of communication were examined, no clear association emerged. We were repeatedly led to the conclusion that communication counts for very little. If the kinds of intensive and highly-skilled -- not to mention expensive -- efforts we invested in fostering family communication do not result in better contraceptive use, it is extremely doubtful that any kind of family involvement will yield dramatic results in terms of contraceptive use.

Why this is so remains an intriguing question. Based on discussions we have had with parents of adolescents, we suspect that there are several different reasons the influence of parents is so slight. First, it appears as though many parents do not want to get directly involved and, certainly, most teenagers are reluctant to encourage involvement. Most parents would prefer that their teenagers defer sexual activity, but seem resigned to the fact that their views are not likely to be the single determining factor. Recognizing that sexual activity is likely to take place, parents want to be sure that their daughters avoid pregnancy. Consequently, many are relieved to discover that their teens are getting contraception. Beyond that, it seems that most are either willing or prefer to respect the adolescent's privacy. In any event, few feel equipped to become directly involved in monitoring the adolescent's sexual behavior.

One of the more interesting aspects of our study concerned the patterns of communication within the family. Different teenagers, as one might expect, share confidences with different family members. Even though the teen's mother was the family member most likely to learn about the clinic visit, the teenagers themselves tended to open up communication with their sisters. Given the different patterns of family communication, then, efforts to promote communication between two or more specified family members are unlikely to succeed.

Before proceeding to the implications of the Kinship Project, Mr. Chairman, I would like to report on the findings of another study with which I was involved. In cooperation with the Family Planning Council of Southeastern Pennsylvania once again, I conducted a study in 1981 of a national sample of family planning clinics to ascertain how they involved parents in their programs. The results were encouraging and clearly contradict the impression that some may have that family planning clinics systematically seek to build a barrier between parents and their teenage children.

The vast majority of family planning programs *are* making efforts to serve parents and have been doing so for a number of years. About six out of 10 agencies provide family counseling and a significant proportion sponsor parent discussion groups, work with parent advisory groups, and hold training workshops to help parents improve their skills as sex educators. Just over half of the agencies surveyed report that their programs included two or more of these activities -- what we called "high-involvement agencies" -- and these activities had been in place for three to nine years.

High-involvement agencies attract a substantial number of parents. About half say that they serve more than 25 parents for every 100 teenagers. Very little of this activity can be explained by external pressure from the government, as most of these programs were serving parents long before the government made parental involvement in family planning programs an issue.

The second part of our analysis centered on the question of what conditions lead an agency to develop family-oriented services. Surprisingly, Planned Parenthood affiliates -- which have been the most vehement and vocal defenders of the adolescent's right to privacy -- have also done the most to promote parental involvement. Apparently, there is no contradiction between providing confidential services to adolescents and gaining parental participation. In general, larger agencies, which presumably have the resources to develop more diverse programs, are more likely to have programs for parents. However, the strongest predictor of parent-oriented programs is the presence of a consumer advisory board. While these boards vary in composition, they generally represent a stimulus to the development of services for parents. It seems plausible that the presence of community representatives on an advisory committee helps to ensure that services are directed toward the families of teenage patients.

Mandatory parental notification procedures, by contrast, do not appear to promote parental involvement. Too often, notification is considered a substitute for programs to really foster parent-teen communication. It appears that consent and notification requirements are generally introduced for reasons that have nothing to do with improving family communication, such as protection against malpractice or negligence suits.

In short, Mr. Chairman, family planning clinics are making significant efforts to work with parents and have been doing so for many years. What is more, their efforts are meeting with some success.

I note that the purpose of this hearing is to consider proposed legislation to express the sense of the Senate that parents of adolescent children should be involved in the care, treatment and counseling of adolescents served by federal assistance programs. I certainly sympathize with that goal and believe that in the case of most health services parental involvement benefits the child. However, where services related to adolescent pregnancy are involved -- as well as some of the other services being considered here today -- the goal of building family ties must be carefully weighed against teenagers' needs for services to preserve their health.

We know that teenagers are sexually active for almost a year before they seek effective contraception. We also know that substantial numbers of sexually active teenagers attending family planning clinics would probably stop coming if their parents were notified. Hardly any would stop having sex and most would use less effective drugstore contraception or no contraception at all. (It is perhaps worth noting that newspaper accounts during the public debate over the administration's parental notification regulation reported significant declines in teenage clinic attendance in many parts of the country.) It seems, then, that a policy of parental notification would only aggravate the already serious problem of unintended adolescent pregnancy in the U.S. Is that a price we want to pay in our desire to increase parent-child communication?

The Kinship Project provides evidence that compulsory notification of parents whose adolescents enroll in family planning clinics is not likely to benefit the teens, either in regard to easier family communication or in regard to contraceptive use. It also points to the complexity of family communication, indicating that a flexible approach to test and evaluate different mechanisms for family involvement is called for, rather than rigid, bureaucratic solutions such as mandatory parental consent or notification.

In light of this evidence, together with the demonstrated efforts of family planning clinics to involve parents, I would hope that this subcommittee would *not* recommend legislation requiring parental involvement in family planning programs for adolescents. The consequences of such a policy for young people and society are simply too great. I believe Congress adopted a prudent approach in 1981 when it amended the federal family planning legislation requiring clinics to encourage patients to involve their families to the extent practical. I would hope that Congress would carefully examine the results of the 1981 amendment before making any further changes on the subject of parental involvement in programs related to adolescent pregnancy.

Thank you Mr. Chairman.

Senator DENTON. I think the best way to do it is to proceed with all four opening statements.

Mr. Potter?

Mr. POTTER. Thank you, Senator.

I appreciate the privilege of appearing before you today in an effort which I hope will assist this committee in their consideration of a uniform national policy for the care, treatment, and counseling of adolescents who are overcoming problems of a rapidly changing society.

My testimony will focus on the problem of teenage sexual activity and specifically on the important undertaking which addresses the problem.

As a citizen, a public high school teacher of 11 years, a coach, and most importantly, a husband and a father of four young children, I am concerned with the overall decline in values that has become so prevalent in the area of sexual conduct and interpersonal relationships among young people all over America.

Sex without love and marriage without commitment has nearly become the norm in our desperately fragile society. A feeling of urgency to, as the ex-singer Janis Joplin once said, "get it while you can," seems to have been taken literally by many of today's youth.

Programs to reduce the many tragic consequences of adolescent sexual activity generally favor one of two approaches. Proponents of the first approach define sexual responsibility in superficial terms. Being sexually responsible simply means avoiding pregnancy and seeking immediate medical attention when V.D. is suspected.

The increases of out-of-wedlock births and abortions among teens is attributed to inadequate contraceptive education and the use of contraception by sexually-active teens is viewed as the solution to adolescent pregnancy problems.

The second and more comprehensive approach to the problem views sexual expression not merely as a biological impulse, but rather as a profoundly meaningful human experience. The deep meaning of sexuality is found in the context of the family, self-respect and respect for others, and in the respect and love for one's future spouse and children. In order to mitigate the problems of teenage pregnancy and abortion, solutions must get at the problems that lead teens to early sexual activity. These solutions must be founded on solid educational principles that uphold the dignity of the individual and of the family.

To summarize this contradiction of philosophies, Senator, I would like to quote Dr. Kingsley Davis from the Journal of Medicine in the State of Georgia. He said, and I quote:

> The current belief that illegitimacy will be reduced if teenage girls are given effective contraceptives is an extension of the same reasoning that created the problem in the first place. It reflects an unwillingness to face problems of social control and social discipline, while trusting some technological device to extricate society from its difficulties.

I am here today, speaking on behalf of an organization that agrees with Dr. Davis and subscribes to this second philosophy.

Teen-Aid, Inc., a Washington State-based, nonprofit, nonsectarian organization, was founded in August 1981 to help reduce the many adverse consequences of premarital sexual activity among teens. Every facet of the organization is aimed at encouraging abstinence as a premarital lifestyle, increasing the understanding of fertility and respect for the power to create life, and promoting strong parent-teen relationships.

Our organization has identified five basic program elements. Briefly stated, these are:

One, the media campaign, which tries to utilize all available media to promote the benefits of abstinence as a premarital lifestyle for teens, and to assist parents in communicating about human sexuality with their children.

The second basic program element is the community education programs—to make available to the community a curriculum in human sexuality, complete with bibliography, to provide audiovisual materials for the course, and to train volunteers to present to individual classes the nature and objectives of Teen-Aid.

Element No. 3 is operation communication—to provide for parents workshops on the subject of human sexuality. This element is designed to improve parent-teen communication and to sponsor workshops for teens to assist them in formulating and expressing their choice to avoid premarital sexual activity.

Element No. 4 is individual counseling. This phase is offered to help teens seeking a framework for understanding their sexuality. This phase, I might add, in the counseling sessions, requires that after the third counseling sessions, either parents are included in the counseling sessions, or the individual is no longer welcome to return.

Element No. 5 is our medical services. We provide screening for sexually transmitted diseases, with the provision that all clients screened must receive counseling as to the advantages of premarital abstinence. Pregnancy testing is available upon request. However, all clients with positive results will be referred to pregnancy counseling services that neither provide nor refer for abortion.

I participated in the founding of Teen-Aid after having taught a contraception-oriented, value-free, sex education course to 10th graders in high school. I came to realize that this approach to sexuality has potentially damaging effects on the students, and that it perhaps even exacerbates the very problems we hope to solve.

My primary involvement with Teen-Aid, then, has been the development of a senior high curriculum that embodies strong values and principles that I believe will foster a healthy understanding of sexuality. The first edition of the curriculum, Sexuality, Commitment, and the Family, which I co-edited, was released in October 1982. Five hundred copies were printed and were sold in less than 1 year to groups in 33 States and 6 Canadian Provinces. And I might add that that was done on a total advertising budget of $4.65. We expect the second edition to be completed in the next month, and we have been receiving 2 to 30 requests per week for the updated curriculum. We are also in the process of creating a junior high curriculum with an expected completion date of this fall.

Since the publication of our senior high curriculum, we have been besieged with requests for the junior high version.

In addition to the curriculum project, Teen-Aid has reached countless teens in eastern Washington and nationwide. We currently have 14 affiliates in 6 States and 2 Canadian Provinces, of which we are quite proud. Each organization is working on a variety of educational programs and on the development of effective educational materials. Our Spokane, WA office alone has completed two videotapes and is working on three others, all of which will aid in the teaching of the senior high curriculum.

For the past several months, Teen-Aid of Spokane has also been providing workshops on sexuality for sex offenders and juvenile offenders in the Juvenile Justice Center in Spokane, which services five counties in eastern Washington. Next month, the clinical phase of the Teen-Aid program will become operational, under the direction of Dr. Al Derby. We will then begin our STD screening and pregnancy testing services.

For the last 2½ years, Teen-Aid has encouraged close cooperation with existing services, both in Spokane and other communities where affiliates are getting under way. The response from community organizations and civic groups to the Teen-Aid concept has generally been very positive and very supportive.

Teen-Aid's commitment to parental involvement is reflected in every phase of the Teen-Aid program. The importance of healthy relationships with parents and family is mentioned five times in the Teen-Aid charter. The primary architects of the counseling program, Dr. Frank Hamilton and Dr. Averly Nelson, state unequivocally that for the counseling sessions to be effective, parents must become involved at as early a stage as possible.

The senior high curriculum recognizes at the outset that the primary responsibility for teaching children about sexuality rests with the parents, and the program involves parents in each lesson through the Parent-Teen Communicators, which are simply take-home summaries of the lessons with suggested questions for discussions.

In the sensitive area of contraceptive education Teen-Aid has compiled information which stresses the advantages of abstinence—that parents may use in discussing contraception with their teens.

Outside the home today, as we know, teenagers are subject to many powerful influences from school, media, and peers. They encounter many forces urging them in the direction of destructive experimentation. The family and supportive organizations such as Teen-Aid can be strong counterforces in the adolescent's favor.

Not every young person who has problems can be reached, but many can. They need and want to be supported in their resolve to redirect the pattern of their lives. They need to know that they need not again become involved in irresponsible behavior that violates their dignity as responsible persons.

Adolescents need adults, especially their parents, to be effective role models. Most of them welcome parents' firm but reasonable limits on their sexual conduct. However, adolescence is also a period of striving for identity and independence from parents. Therefore, positive peer relationships with both sexes are critical in order for teens to work through their sexual problems. To exclude parents from this sensitive process would certainly create a tragic void in the lives of most troubled youth.

Gentlemen, I submit to you that Federal legislation that includes the involvement of parents in such matters as these is a necessity. It is our hope that you will continue to address this issue in a very aggressive manner.

Thank you.

Senator DENTON. Thank you very much, Mr. Potter.

[The prepared statement of Mr. Potter follows:]

Teen Aid Incorporated: Steve Potter

Thank you for the privilege of appearing before you today in an effort which I hope will assist the committee in their consideration of a uniform national policy for the care, treatment and counseling of adolescents who are overcoming the problems of a rapidly changing society. My testimony will focus on the problem of teen-age sexual activity, and specifically on an important undertaking which addresses that problem.

As a citizen, a public high school teacher of eleven years, a coach and, most importantly, a father of four young children, I'm concerned with the overall decline in values that has become so prevalent in the area of sexual conduct and interpersonal relationships among young people all over America. Sex without love and marriage; without commitment, has nearly become the norm in our desperately fragile society. A feeling of urgency to, as Janis Joplin said years ago "Get it while you can", seems to have been taken literally by many of today's youth.

Programs to reduce the many tragic consequences of adolescent sexual activity generally favor one of two approaches. Proponents of the first approach define sexual responsibility in superficial terms. Being sexually responsible means avoiding pregnancy and seeking immediate medical attention when V.D. is suspected. The increases in out-of-wedlock births and abortions among teens is attributed to inadequate contraceptive education, and use of contraceptives by sexually active teens is viewed as the solution to the adolescent pregnancy problem.

The second, more comprehensive approach to the problem, views sexual expression not merely as a biological impulse, but rather as a profoundly meaningful human experience. The deep meaning of sexuality is found in the context of the family, self-respect and respect for others, and in the respect and love for one's future spouse and children. In order to mitigate the problems of teen pregnancy and abortion, solutions must get at the problems that lead teens into early sexual activity. These solutions must be founded on solid educational principles that uphold the dignity of the individual and the family. As Dr. Kingsley Davis has said, "The current belief that illegitimacy will be reduced if teenage girls are given effective contraceptives is an extension of the same reasoning that created the problem in the first place. It reflects an unwillingness to face problems of social control and social discipline while trusting some technological device to extricate society from its difficulties." I am here today speaking in behalf of an organization that agrees with Dr. Davis and subscribes to this second, and I believe more effective, approach.

Teen-Aid, Incorporated, a non-profit, non-sectarian organization, was founded in August, 1981, to help reduce the many adverse consequences of premarital sexual activity among teens. Every facet of the organization is aimed at encouraging abstinence as a premarital lifestyle, increasing the understanding of fertility and respect for the power to create life, and promoting strong parent-teen relationships.

The organization has identified five basic program elements. Briefly stated, these are:

1. Media campaign--to utilize all available media to promote the benefits of abstinence as a premarital lifestyle for teens; and to assist parents in communicating about human sexuality with their children.
2. Community Education--to make available to the community (e.g., schools, churches, and families) a curriculum in human sexuality, complete with bibliography; to provide audio-visual materials for the course, and to train volunteers to present to individual classes the nature and objectives of Teen-Aid.
3. Operation Communication--to provide for parents workshops on the subject of human sexuality, designed to improve parent-teen communication; and to sponsor workshops for teens to assist them in formulating and

expressing their choice to avoid premarital sexual activity.

4. Individual Counseling--to offer help to teens seeking a framework for understanding their sexuality.

5. Medical Services--to provide screening for sexually-transmitted diseases, with the provision that all clients screened must receive counseling as to the advantages of premarital abstinence. Pregnancy testing will be available upon request. All clients with positive results will be referred to pregnancy counseling services that neither provide nor refer for abortion.

I participated in the founding of Teen-Aid after having taught a contraception-oriented, "value-free" sex education course to sophomores in high school. I came to realize that this approach to sexuality has potentially damaging effects on the students and that it perhaps even exacerbates the very problems we hope to solve. My primary involvement with Teen-Aid, then, has been the development of a senior high curriculum that embodies strong values and principles that I believe will foster a healthy understanding of sexuality. The first edition of the curriculum, Sexuality, Commitment and Family, which I co-edited, was released in October of 1982. Five hundred copies were printed and were sold in less than one year to groups in 33 states and six Canadian provinces. We expect the second edition to be completed next month and have been receiving 2 to 30 requests per week for the updated curriculum. We are also in the process of creating a junior high curriculum with an expected completion date of this fall. Since the publication of our senior high curriculum, we have been beseiged with requests for the junior high version.

In addition to the curriculum project, Teen-Aid has reached countless teens in Eastern Washington and nationwide. We currently have 14 affiliates in 6 states and 2 Canadian Provinces. Each organization is working on a variety of educational programs and on the development of effective educational materials. Our Spokane office alone has completed two video tapes and is working on three others, all of which will aid in the teaching of the curriculum. For the past several months, Teen-Aid of Spokane has also been providing workshops on sexuality for sex offenders and juvenile offenders and the Juvenile Justice Center in Spokane which serves five counties in Eastern Washington.

Next month, the clinical phase of the Teen-Aid program will become operational when, under the direction of Al Derby, M.D. (Ob-Gyn), we begin our STD screening and pregnancy testing services.

For the last two and one half years, Teen-Aid has encouraged close cooperation with existing services both in Spokane and in other communities where Teen-Aid affiliates are getting under way. The response from community organizations and civic groups to the Teen-Aid concept has generally been a very positive, supportive one.

Teen-Aid's commitment to parental involvement is reflected in every phase of the Teen-Aid program. The importance of healthy relationships with parents and family is mentioned five times in the Teen-Aid Chapter. The primary architects of the counseling porgram, Frank Hamilton, Ph.D. (Psychology) and Averly Nelson, M.S. (Psychiatry) state unequivocally that for the counselling sessions to be effective, parents must become involved at as early a stage as possible. The senior high curriculum recognizes at the outset that "the primary responsibility for teaching children about sexuality rests with parents", and the program involves parents in each lesson through the "Parent-Teen Communicators"--take-home summaries of the lessons with suggested questions for discussion. And in the sensitive area of contraceptive education, Teen-Aid has complied information which stresses the advantages of abstinence--that parents may use in discussing constraception with their teens.

Outside the home today, teenagers are subject to many powerful influences from school, media, and peers. They encounter many forces urging them in the direction of destructive experimentation. The family and supportive organizations such as Teen-Aid can be strong counterforces in their favor.

Not every young person who has problems can be reached, but many can. They need and want to be supported in their resolve to redirect the pattern of their lives. They need to know that they need not again become involved in irresponsible behavior that violates their dignity as responsible persons.

Adolescents need adults, especially their parents, to be effective role models. Most of them welcome parents' firm but reasonable limits on their sexual conduct. However, adolescence is also a period of striving for identity and independence from parents. Therefore, positive peer relationships with both sexes are crucial in order for teens to work through their sexual problems. To exclude parents from this sensitive process would certainly create a tragic void in the lives of most troubled youth.

Gentlemen, I submit to you that federal legislation that includes the involvement of parents in matters such as these is a necessity. It is my hope that you will continue to address this issue in an aggressive manner.

Senator DENTON. Dr. Rekers?

Dr. REKERS. Thank you, Mr. Chairman, for inviting me to participate in this important hearing.

I speak today from my experience as a practicing family therapist who has worked with adolescents and their families over the past 10 years in private practice, as a former faculty member and staff psychologist at the UCLA Psychology Clinic, and more recently as the chief psychologist in the Division of Child and Adolescent Psychiatry at the University of Florida Medical School. I have also conducted for many years a major research project with Federal funding on sexual identity development. So I speak from my professional experience working with families and youth, as well as from the viewpoint of a concerned individual private citizen.

Government policy with regard to parental involvement in social service delivery to adolescents can take one of three basic positions. On the one hand, the general policy can be one of usually operating in routine secrecy from the adolescent's parents, with occasional exceptions involving parents, or perhaps relying only on the adolescent to voluntarily notifying their parents. On the other hand, the policy can be one of routinely involving the parents, with occasional exceptions made where parents are not involved for documented extraordinary circumstances that are judged to be in the best interests of the adolescent because of parental irresponsibility. The third position is really a version of the second, and would require parental consent for all interventions into adolescents' lives except in those extreme cases of parental irresponsibility.

Just because disclosure and involvement of parents may not work for some individual exceptional cases, it is not sufficient reason for treating the majority of cases with secrecy from the parents. The exception should not govern the rule.

If parental involvement is denied, the burden of proof should be heavily on the agency to document the reason for the exception in the same manner that a court bears the responsibility to find documented reasons to sever other forms of parental custody, for example.

A blanket policy of routine secrecy would irresponsibly remove parental rights from the vast majority of responsible parents in our Nation, and it makes the scientifically undemonstrated and unwarranted assumption that such parental involvement would be detrimental to the welfare of the vast majority of adolescents served.

To suggest that most adolescents would not receive help for their sexual adjustment unless contraceptives are routinely dispensed covertly, is to capitulate to the illogical proposition that immature sexual intercourse by the adolescent is always an individual problem of the teenager instead of representing an underlying family relationship problem. A strong, adaptive, moral, and healthy family relationship can produce character traits of self-restraint, self-control and self-protective abstinence. The strong family can also provide the love, affirmation, acceptance and social support to the teenager, which helps prevent temptations to premature sexual intercourse for a temporary sense of acceptance and belonging.

Because premature sexual intercourse can be in part, symptomatic of an underlying family problem, the agency practice of secretly dispensing contraceptives may actually compound the underlying weakness of a family problem, rather than truly treating the root cause. I am concerned for the welfare of adolescents, because in the long run, the teenager with such a covert policy is worse off than he or she was before receiving the contraceptives. The teenager is worse off when he or she has been isolated further from the family. The teenager is worse off because he or she has been given a false sense of freedom from physical risk for adverse consequences attending the epidemic of sexually transmitted diseases. The teenager is worse off because he or she has received what is often perceived as official approval to participate in an emotionally risky behavior pattern. The teenager is worse off because he or she has been implicitly given an endorsement to participate in behavior patterns without the consideration of the morality of sexual exploitation.

Summarizing the results of research on 480 strong families in our Nation and 180 strong families in South America, Dr. Nick Stinnet concluded:

> The quest for self-fulfillment during the 20th century has developed into a major goal in American culture (Yankelovich, 1981). However, in our preoccupation with this objective, we have neglected the family and lost sight of the fact that so much of the foundation necessary to facilitate the lifelong process of individual self-fulfillment is developed within strong, healthy families. We have considerable evidence that the quality of family life is extremely important to our emotional well-being, our happiness, and our mental health as individuals. We know that poor relationships within the family are very closely related to many problems in society.

The family is potentially a powerful source of emotional support and reassuring acceptance, warmth and affirmation, as Dr. Strommen's research demonstrates. Any government policy of human service delivery that risks tampering with the potential sources of love, affection, openness and protection of the parent-child relationship is poetntially increasing the risk of additional cases of immature sexual acting out. Instead, federally funded programs for adolescents should carry the mandate to deliver family counseling and family life education designed to restore and enhance love and communication between parents and teenagers with the goal of strengthening the family.

A Government-allowed policy of routine secrecy in dispensing contraceptives to adolescents potentially risks a further breakdown of the cohesion and family boundaries which contemporary family theories postulate are necessary for individual and family well-being. The research of Dolores Curran (1983), mentioned this morning, and that of Nick Stinnett (1983) on the characteristics of healthy, strong families, has established that the traits of mutual trust, shared responsibility, and open communication are central to supportive and adaptive functioning in family life. This being the case, and given, in addition, the finding that family secrets create dysfunctional stress on a family, I would expect, as a practicing family therapist, that secret services to adolescents may produce the negative side effect of creating further barriers, blocking the emotional support and care that could otherwise be received by the adolescent from the family system.

By covertly collaborating with the adolescent's symptom of rebellion against the family, the adolescent's future potential for receiving corrective emotional support and moral guidance from the family is further disrupted, deepening the root problem even further.

Open communication, family trust, and shared responsibility in the family are all potentially undermined by secret dispensing of contraceptives by social agencies. As Dr. Merton Strommen reported this morning regarding his research, both parents and adolescents do not want this kind of effect. Instead, the majority want a happy family with open communication.

Every human being, including adolescents, need social support in life. Pilisuk and Parks (1983) recently conducted a review on the need of social support for children and have found the family unit as being critical. These reviewers found that a substantial number of children have "needs for supportive assistance from families that are not being met either by kinship networks, by friendship networks, or by association with formal service agencies."

And they go on to say that, "In developed countries, there has been a gradual transition to formal bureaucratic institutions of functions once though to be unique to the family. The number of social services provided is legion, but their adequacy in meeting the economic, social and health needs of individuals is questionable."

The intimate, parent-adolescent ties in the family should be, therefore, enhanced and encouraged, not undermined and replaced, by professionals in social service agencies.

For these reasons, I personally support and favor the proposed Senate resolution requiring parental involvement in Federally-funded adolescent programs, with the very narrow exceptions noted therein.

If involvement with the parent is deliberately excluded in sexual counseling and contraceptive dispensing for adolescents, the adolescent-parent communication and relationship is disrupted. To exclude parental involvement merely to avoid a parent-adolescent conflict over sexual intercourse is ultimately detrimental to the teenager's development of maturity, well-being and adjustment.

In a very recent book chapter on preventing parent-adolescent crises, Catron and Catron in 1983 concluded: "It is our assumption that conflicts are a normal, inevitable, and even essential part of the parent-adolescent experience. In fact, absence of any conflict may indicate alienation or domination. Further, these conflicts are not necessarily negative and can, in fact, lead to a strengthening of the parent-adolescent bonds. In contract to conflict, most crises are not inevitable. Severe disruption of a relationship is generally not desired by either the parent or the adolescent."

These family psychologists provided guidelines for preventing parent-adolescent crises, and they emphasized open communication in the family regarding important decisions. And I suggest that decisions regarding sexual activity are very important.

They say, "To the adolescent, the process by which decisions are made and conflicts resolved may be as important as the actual decision itself. Also, whether a conflict becomes a crisis may be more closely related to how parents and adolescents treat each other during negotiation than to the difference themselves.

"By giving each other full attention and by taking seriously the concerns and feelings of the other, parent-adolescent communications will be enhanced and the negotiation process fostered. In decisionmaking, nothing takes the place of good communication—and plenty of it."

Instead of disrupting, then, this parent-adolescent communication, agencies helping teenagers should encourage open communication in the family.

In a study by Olson and McCubbin, in 1983, a small percentage, 12 percent, of adolescents reported involvement in sexual intercourse as a family stressor and source of strain. If the adolescent's premarital sexual intercourse or plan for sexual intercourse is a potential source of conflict in the parent-adolescent communications, federally-funded social service agencies should be directed to use family counseling and family life education methods to enhance that communication, and to endorse abstinence.

On the basis of my more extensive written testimony, I would conclude that sexual intercourse is not acceptable prior to marriage because there is a genuine difference in personal consequences when all the prerequisites for an ideal sexual relationship are present, as compared to situations where any of these prerequisites are missing. A sexual relationship has its greatest benefits for the person, for a couple, and for any potential children resulting from their physical union when all these features are present: (1) mutual physical consent; (2) consideration of reputation; (3) genuine love and affection; (4) nonexploitiveness with communication; (5) personal commitment to living together; (6) public commitment, and (7) a legal commitment with the protection of a State marriage license.

Stinnett (1983) and Curran's (1983) research among others is suggestive that a number 8 might well be a religious commitment by a covenant vow.

Unacceptable risks to the welfare of all parties arise when any of these ingredients for a maximum sexual experience are missing, and teenagers in particular are very vulnerable to exploitation by adults and peer sexual partners if they consent to unmarried sexual intercourse.

Therefore, out of our compassion and care for the adolescent, we should respect this delicate and nurturant family system and respect the moral dimension in human sexuality. The adolescent boy and girl need to learn a healthy and mature respect for their bodies. The family is the incubator for learning the response of love. But sex is disassociated from love if our social policy endorses a degraded view of sexuality that actually reduces it to flesh-against-flesh relationships which can be perceived as being officially sanctioned by the covert dispensing of contraceptive technology. This is an empty, mechanical, biological, recreational attitude toward sexuality, but sexual expression has its only true, full meaning in the depths of the precious and special lifetime commitment called marital love. To dispense contraceptive technology to unmarried teenagers without their parental involvement can indicate and communicate an individualistic attitude that devalues marriage.

Parents have a responsibility to transmit the values of morality and responsible decisionmaking to their adolescent children.

I have personally often observed a very interesting thing—that individuals who verbalize the most permissive values regarding sexual conduct for other people become very protective and concerned with morality when the conversation turns to the ethical expectations they have for their own adolescent children. This suggests that there is a naturally more protective and caring expectation that parents normally have for their own offspring, compared to a laissez-faire noninvolvement that adults often display toward teenagers who are not their own precious offspring to nurture, protect, and cherish.

The parent, I contend, is more likely to have the depth of caring, the attachment, and the bonding that would have greater persuasive power to convince the adolescent that abstinence is superior to premarital sexual intercourse.

This morning, we heard that most parents prefer that their adolescents postpone sexual intercourse, and the George Gallup findings, you indicated, found that 8 out of 10 adults believe in sex education with parental consent. I would conclude, then, that we should never resign ourselves to accept the unacceptable practice of premarital intercourse as though it is inevitable, but that Government programs should indeed, cooperate with parents and be mandated to cooperate with parents, to help them to carry out their own primary responsibility to provide education for responsible sexuality in their children.

Thank you.

Senator Denton. Thank you very much, Dr. Rekers.

[The prepared statement of Dr. Rekers follows:]

Parental Involvement with Agencies Serving Adolescents in Crisis: Adolescent Sexuality and Family Well-Being

Testimony by:

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Presented to:

United States Senate Subcommittee on Family and Human Services
Hearing on "Parental Involvement with their Adolescents in Crisis:
The Federal Government's Response"

February 24, 1984

Government policy with regard to parental involvement in social service delivery to adolescents can take one of ~~two~~ 2 basic positions: On the one hand, the general policy can be one of usually operating in [illegible] secrecy from the adolescents' parents with occasional exceptions involving parents. On the other hand, the general policy can be one of usually involving the parents with occasional exceptions where parents are not involved for documented extraordinary circumstances that are judged to be in the best interests of the adolescent because of parental irresponsibility. The [illegible]

Just because disclosure and involvement of parents may not work for some individual exceptional cases is not sufficient reason for treating the majority of cases with secrecy from parents. The exception should not govern the general rule. If parental involvement is denied, the burden of proof should be heavily on the agency to document the reason for the exception. A blanket policy of universal secrecy would irresponsibly remove parental rights from the vast majority of responsible parents in our nation.

To suggest that most adolescents would not receive the "help" of dispensed contraceptives unless they were secretly dispensed, is to capitulate to the illogical proposition that immature sexual intercourse by the adolescent is an individual problem of the teenager instead of representing an underlying family problem. A strong, adaptive, moral and healthy family relationship produces the character traits of self-restraint, self-control, and self-protective abstinence, together with the love, affirmation, acceptance and social support to the teenager which helps prevent temptations to premature sexual intercourse for a temporary sense of acceptance and belonging.

Because premature sexual intercourse is, in part, symptomatic of an underlying family problem, the so-called "help" of secretly dispensed contraceptives strikes a blow at the underlying weakness of a family problem rather than treating the root cause. In the long run, the teenager is worse off than before receiving the contraceptive. The teenager is worse off because he or she has been isolated further from the family. The teenager is worse off because he or she has been given a false sense of freedom from physical risk for adverse consequences attending the epidemic of sexually-transmitted diseases. The teenager is worse off because he or she has received official approval to participate in an emotionally risky behavior pattern. The teenager is worse off because he or she has been implicitly given an endorsement to participate in behavior patterns without consideration of the morality of sexual exploitation.

The Adolescent's Need for Family Well-Being

Summarizing the results of research of 480 strong families in our nation and 180 strong families in South America, Dr. Nick Stinnett concluded:

"The quest for self-fulfillment during the twentieth century has developed into a major goal in American culture (Yankelovich, 1981). However, in our preoccupation with this objective we have neglected the family and lost sight of the fact that so much of the foundation necessary to facilitate the life-long process of individual self-fulfillment (such as the development of interpersonal competence, self-confidence, self-esteem, respect for self and others, and the vision and knowledge that life can be enriched) is developed within strong, healthy families.

"We have considerable evidence that the quality of family life is extremely important to our emotional well-being, our happiness, and our mental health as individuals. We know that poor relationships within the family are very closely related to many problems in society (such as juvenile delinquency and domestic abuse)" (page 27).

The adolescent faces the risks of the developmental inclination toward rebellion, and his or her needs for acceptance and inclusion can contribute to the immature response of premature sexual intercourse with its attending risk to physical and emotional health. The family is potentially a powerful source of emotional support and reassuring acceptance, warmth and affirmation. Any government policy of human service delivery that risks tampering with the sources of love, affection, openness and protection of the parent-child relationship is only increasing the risk of additional cases of immature sexual acting out.

135 A government-allowed policy of routine secrecy in dispensing contraceptives to adolescents risks a breakdown of the cohesion and family boundaries which contemporary family theories postulate are necessary for individual and family well-being. The research of Dolores Curran (1983) and Nick Stinnett (1983) on the characteristics of healthy, strong families has

established that the traits of mutual trust, shared responsibility, and open communication are central to fulfillment in family life. This being the case, and given the *finding* that family secrets create dysfunctional stress upon a family, I would expect that secret services to adolescents typically result in further problems for the adolescent to receive emotional support and care from the family system. By treating the adolescent's symptom of rebellion against the family, the adolescent's potential for receiving corrective emotional support and moral guidance from the family is further disrupted, deepening the root problem even further. Open communication, family trust and shared responsibility in the family are all undermined by secret dispensing of contraceptives by social agencies.

When teenagers need help in the area of sexuality, they might turn to family, friends, or an agency. The type of family relationships of that individual is related to help-seeking behavior; Horwitz (1978) reviewed evidence that the extended kin network will provides help for the nuclear family, and that kin, unlike friends, provide the extensive kinds of help involving long-term commitments and permanent ties.

Every human being, including adolescents, need social support in life. Social support has been defined as "...a set of exhanges which provide the individual with material and physical assistance, social contact and emotional sharing, as well as the sense that one is the continuing object of concern by other" (Pilisuk & Parks, 1983), p. 138). For the adolescent, the family is usually the central source of social support. In a review of the literature, Philisuk and Parks (1983) have delineated the supportive needs of children. They concluded, "The social supports brought about through association with the family unit as a whole appear to be critical to the family well-being." (p. 141). These reviewers found that there is a substantial number of children "...with needs for supportive assistance from families that are not being met either by kinship networks, by friendship networks, or by association with formal service organizations." They go on to observe, "In developed countries there has been a gradual transition to formal bureaucratic institutions of functions once thought to be unique to the family.... The number of social services provided is legion, but their adequacy in meeting the economic, social and health needs of individuals is questionable" (Pilisuk and Parks, 1983, page 143). In contrast, these investigators reviewed the evidence that indicates that "...a small, densely interconnected network of intimate ties remains critical to individual well-being" (page 146).

Open Family Communication Promotes Adolescent Adjustment

Adolescents do not grow in a vacuum, but they develop to social and emotional maturity in relationship with their family members. Maturing in adolescence involves the adolescent confronting the significant adult (typically the parent) and thereby developing a new form of relating. If the adolescent is separated from the parent either physically or emotionally, this important developmental task is incomplete and results in a level of immaturity persisting into the adult years. For example, federal policy currently recognizes that adolescents requiring foster care simultaneously need the responsible social service agency to work with their family; an adolescent child is removed from the biological parents only as a temporary measure allowing remedial work with the parents with the eventual attempted goal of permanency placement back to the home of origin where ever possible. Tragically, past foster home placements resulted in the travesty of ignoring the original needs in the original home. By focusing only on serving the adolescent as an individual, the youth were severed from their home, no efforts were made to strengthen their original family, and so the adolsecent got "lost" in the system of social services--being transferred from one temporary placement to another with little hope of permanency.

In the area of problems with adolescent intercourse, we should not repeat the mistake of treating the adolescent separately from the adolescent's family. If involvement with the parents is deliberately excluded in sexual counseling and contraceptive dispensing for adolescents, the adolescent-parent communication relation is disrupted. To exclude parental involvement merely to avoid a parent-adolescent conflict over sexual intercourse is ultimately detrimental to the teenager's maturity and well-being.

In a very recent book chapter on "Preventing parent-adolescent crises," Catron and Catron (1983) have concluded:

> "It is our assumption that conflicts are a normal, inevitable, and even essential part of the parent-adolescent experience. In fact, absence of any conflict may indicate alienation or domination. Further, these conflicts are not necessarily negative and can, in fact, lead to a strengthening of parent-adolescent bonds.
>
> "In contrast to conflict, most crises are not inevitable. Severe disruption of a relationship is generally not desired by either the parent or the adolescent." (page 149).

These family psychologists provided guidelines for preventing parent-adolescent crises and they emphasized open communication in the family regarding important decisions:

> "To the adolescent, the process by which decisions are made and conflicts resolved may be as important as the actual decision itself. Also, whether a conflict becomes a crisis may be more closely related

to the differences themselves.

"...By giving each other full attention and by taking seriously the concerns and feelings of the other, parent-adolescent communications will be enhanced and the negotiation process fostered. In decision making, nothing takes the place of good communication-- and plenty of it" (page 156). Instead of disrupting parent-to-adolescent communication, agencies helping teenager should encourage open communication in the family.

In the study by Olson and McCubbin (1983), "...the adolescents themselves reported that their alcohol, drug, or cigarette use increased problems in their family. A small percentage (12 percent) of adolescents reported involvement in sexual intercourse as another family stressor and source of strain" (page 229).

However, secret social services to adolescents planning sexual intercourse is really only a symptomatic "bandaid solution" to a much more profound and complex problem. It is a "bandaid solution" because it does not meet the underlying dynamics of family problems. Family adaptability and individual adjustment has been related to family cohesion and the structure of normal family boundaries. Family systems models of family process would predict dysfunctional consequences to official endorsement of family isolation by such secrecy. Undermining open communication in the family, secret dispensing of contraceptives to adolescents will isolate them from their family ties.

According to Olson and McCubbin (1983), "Communication is viewed as an underlying and facilitating dimension of the Circumplex Model. Communication facilitates the movement of families on each of the two major dimensions of family adaptability and family cohesion" (Page 221).

Risks Associated With Premarital Sexual Intercourse

The logic of secretly supplying contraceptives to minor adolescents strikes me as reasonable as capitulating to the argument that a teenager will abuse drugs anyway, so we may as well secretly write prescriptions for the illicit drug at a medical clinic so we at least know that the drug is purer than the street variety. The question remains, does the secret prescription contibute to or condone an immature and risky behavior which has real negative physical, emotional and social consequences? Does the dispensing of contraceptives to adolescents protect them from all physical risk of harm by sexually-transmitted diseases? The answer is clearly "no". Does the secret dispensing of contraceptives to adolescents protect them from all emotional risk of harm from premature sexual intercourse? The answer is that no research study has demonstrated any such total protection from emotional harm.

Clearly, the option of sexual abstinence before marriage holds the greatest potential for protecting the adolescent from the risks of emotional harm and physical harm from sexually-transmitted diseases (Schumm and Rekers, 1984). Secret dispensing of contraceptives is deceptive in that it implies a false sense of freedom from risk when in fact it provides only probabilistic protection from only one consequence (pregnancy) among an array of many serious risks to sexual intercourse outside the protective relationship of marriage. Easier access to birth control methods has been cited as a factor in itself which influences young people to be involved in sexual intercourse (Maskay & Juhasz, 1983).

Permissive sexual intercourse may adversely affect an adolescent's reputation and their ultimate range of choice in potential marital partners. At least one recent study (Istvan & Griffitt, 1980) suggests that the desirability of highly sexually experienced women for marriage is quite a bit less than for mere dating, even among men who are highly experienced themselves--a manifestation perhaps of the double standard at work. As Josh McDowell saysin his university lectures on "Maximum Sex," a lot of guys who won't buy used furniture are themselves in the antiquing business (McDowell & Lewis, 1980). The "Of course I'll respect you in the morning" line is not true in most cases. In fact, Weis and Slosnerick (1981) have observed a significant association between sexual permissiveness and a tendency to disassociate sex and love.

Recreational sex is not acceptable for adolescents because of the inevitable negative physical and emotional risks, with or without attendant contraceptive devices. Social agencies with federal funding should not endorse such risky and dangerous activity among teenager, especially in secrete alliance with the adolescent in secret from the parent.

Instead, adolescents need to be warned about the danger and actual extent of sexual exploitation, especially of women. Faced with concrete, indisputable, short-term benefits in a very active sexual relationship, adolsecants do not have sufficient presence of mind to adequately weigh potential long-term costs for themselves or the other person. No doubt some will feel quite content with their decisions years later, but the majority probably do not and would have made different decisions if they had been able to accurately anticipate all of the consequences of their decisions. Many times two persons may think they are both following the same conditional standard, when in fact one party has no intentions of the same long term relationship as does the other (Newcomb, 1979). The conditional sexual standards beg for exploitation to occur, with the immediacy of substantial short-term gains making it all too easy to rationalize one's behavior, to overlook or minimize things that are important to building a relationship in the long run, or to disregard the long-term welfare of oneself or the other person. Unfortunately, it is easy to deceive *even oneself* about one's intentions or the true meaning of one's words. If one realizes that the easiest way to quick gratification of one's sexual tensions in a relationship is to say certain combinations of words (e.g., "I really love you" or "I really do think we ougth to consider marriage someday"), then it becomes very easy to think "Well, I really do love her sort of, in my own way (even though she may not think of it quite the same way)." It is amazing how cheap such terribly significant but empty words can become in such situations.

We also need to ask, "What effect do conditional sexual standards held before marriage have on later marriage?" Premarital sexual attitudes and behavior are highly correlated with projected extramarital sexual behavior (Bukstel *et al.*, 1978). The story that "sure, I've messed around, but once I get married I will never do it again" should be accepted with great caution. Even if a person avoids some form of exploitation in the premarital relationship that exploitation might occur later after marriage when expectations concerning extramarital sexual activity could be violated.

It is ironic that Reiss (1981) and others associate traditionalism with with a sexual inequality bias when (in our observation) it is the conditional standards rather than the traditional standards that leave the woman most vulnerable to sexual exploitation. Requirements on the male to make a commitment ("put up or shut up") would seem to be a deterrent to easy "lines" about how much affection or personal commitment might be involved in exchange for sexual favors. The traditional standards are the ones that best promote sexual equality.

We should be also concerned about the potential for premature sex to inhibit communication in a developing relationship. While it is tough to communicate, it's easy to make love; thus, it is all too easy to soon have an imbalanced relationship (Lucado, 1983). How easy is it to continually avoid dealing with touchy but important issues through various levels of sexual activity, even at levels below sexual intercourse (Mahoney, 1980). Once an imbalance develops between emotional intimacy and physical intimacy, the effect can spiral in an escalating fashion as more and more sex is needed to offset growing doubt about the underlying strength of the relationship.

However, many feel that the conditional standards permit one to test a relationship prior to making the commitment to marry someone. Of course, as long as someone knows that they are being scrutinized for signs of "incompatibility," there is probably a tendency to avoid letting down one's guard to reveal the "real me," as occurs quite often after marriage. Therefore, for theoretical reasons it is doubtful that premarital testing can ever be completely effective. Yet it would seem to be an attractive way of insuring that one at least does not marry a totally unsuitable partner. However, current research, even by those who have expected otherwise (Watson, 1983), tends to find little support for the proposition that even cohabitation, the closest parallel to marriage, can help one select out good or bad partners in a way that will ultimately increase one's eventual marital satisfaction. Likewise, we know of no research that supports the ability of cohabitation or premarital intercourse to strengthen a weak relationship, though it is possible for relationships that were strong to begin with to survive premarital intercourse (Kirkendall, 1951). In this regard, the wife of a professor at Purdue University stated a profound truth in her comment, "You aren't married until you're married." Conditional standards often suggest that the marital state can be established outside of marriage, at least in terms of the relative rewards and costs; however, such aspirations are simply unrealisitc, if not misleading, too often a way of trying to kill the goose for its golden eggs rather then being content with the more gradual development of an intimate sexual relationship.

Although the conditional standards are notwithout positive aspects, especially as compared only to purely permissive standards, we believe the commitment-oriented standards offer greater rewards in the long run, as well as tending to minimize some of the profound risks that are inherent in the conditional standards.

Too often commitment-oriented standards have been presented in exclusively negative terms, i.e., *no sex before marriage* rather than in positive terms. In contrast, adolescents need to be taught about what makes for the *best* sex, not just "good" sex. Observation, logic, and years of marriage counseling experience contribute to the conclusion that commitment-oriented standards yield the highest probability of long-term benefits within the context of real life with its daily frustrations and responsibilities.

Sex reserved for marriage facilitates an exclusive association of sexual pleasure with the marital relationship and *only* the marital relationship, so a couple can genuinely say, "This is something unique in space and time to our relationship alone. No one else has or will ever share it. It is something of ourselves and for ourselves that is very, very special, for us alone to cherish and enjoy." We question whether something quite precious is not lost when a couple cannot honestly say such things about their relatinship. In this type of covenant, each party commits themselves not only to an enduring relationship but to the other party's long-term welfare, specifically, personally, and unconditionally. We do not say, "I will hang around as long as you make me feel reasonably happy, after that I might leave." Rather, we say, "I will be here for you, with you regardless of what you may say or do, even if it means you take the opportunity of my vulnerability to exploit me," to loosely paraphrase an old wedding vow expressing enduring commitment "for better or for worse." It is an agreement not to be entered into lightly. But it offers the greatest potential for personal growth and fulfillment of the many alternatives for sexual relationships that are available. Sex is a wonderfully appropriate vehicle for celebrating such an intimate and lasting love relationship, and that this kind of marriage is the most desirable environment in which to conceive and nurture children.

Sexual intercourse is not acceptable prior to marriage because there is a genuine difference in personal consequences when all of prerequisites for an ideal sexual relationships are present as compared to situations where any of these prerequisites are missing. A sexual relationship has its greatest benefits for the person, a couple, and any potential children resulting from their physical union when all of these features are present: mutual physical consent, consideration of reputation, genuine love and affection, nonexploitiveness with communication, personal commitment to living together, public commitment, legal commitment with the protection of a state marriage license and a religious commitment by a covenant vow. Unacceptable risks to the welfare fo all parties are present when any of these ingredients for a maximum sexual experience are missing.

Parental Involvement for the Adolescent's Best Welfare

Care and compassion for the adolescent requires a respect for the delicate and nurturant family system and respect for the moral dimension of human sexuality. The adolescent boy and girl need to learn a healthy and mature respect for their bodies. The family is the incubator for learning the response of love. But love has no meaning if social policy endorses a degraded view of sexuality that reduces it to a flesh against flesh relationship which can be officially sanctioned by the secret dispensing of contraceptive technology. This is an empty, mechanical, biological, recreational attitude toward sexuality which has its only true meaning in the depths of the precious and special lifetime commitment called married love. To dispense contraceptive technology -- to unmarried teenagers without their parental involvement communicates an attitude that devalues marriage. Such a policy leads to the emotional scars of bitter disappointment in the temporary illusory quest of "making love." Such a policy leads to the diseased bodies of sexually-transmitted disease. Such a policy preaches instant gratification instead of self-control to build permanence and stability in life.

If social service agencies treat the symptom of adolescent sexual intercourse instead of addressing the adolescent's root problems, the adolescent, their family and the nation -- will continue to suffer adverse consequences. It is frequently the case that the adolescent involved in promiscuous sexuality, in alcohol abuse or drug abuse is "crying for help" with underlying emotional problems. A pilot program by the Appalacian Regional Commission (American Family, volume VI, no. 9, October 1983) provided for emotional needs of pregnant adolescent women by pairing them with grandparents or elderly individuals. Bryant (1981) found that contact with the grandparents contribute to pro-social development. How much more strategic it would be to provide family support and involvement by parents and grandparents to prevent the feelings of emotional emptiness and loneliness that can contribute to immature and premature searches for intimacy through sexual intercourse within the peer group.

If a government funded agency sanctions the secret dispensing of contraceptives, they are officially endorsing a subterfuging of the parent-child relationship and endorsing a value system which views sexual intercourse as involving no significant moral evaluation. Parents and grandparents have a responsibility to transmit the values of morality and responsible decision-making to their adolescent children and grandchildren. I have often observed individuals who verbalize the most permissive values regarding sexual conduct for others become very protective and moralistic when the conversation turns to the ethical expectations they have for their own adolescent children. There is a naturally more protective and caring expectation that parents normally have for their own offspring, compared to the laisse faire non-involvement that adults often display toward teenagers who are not their own precious offspring to nurture, protect and cherish. The parent, I contend, is more likely to have the depth of caring and attachment that would have greater persuasive power to convince the adolescent that abstinence is superior to sexual intercourse with the fallible and artificial contraceptive technology.

Federal policy regarding providing services to the adolescent should be guided by the humanitarian motive to care and protect the vulnerable and precious resource of youth. Federal policy should not endorse any practice which would place the adolescent at unnecssary risk of physical or emotional harm or injury. In the area of adolescent sexual intercourse, both the boy and girl are at risk for physical and emotional harm and exploitation. As a nation, we should never capitulate to a "second best" policy for our children and youth. We should aim for their very best welfare, and this requires that we shelter them from unnecessary risk and that we support their families as a primary source of love, caring and support for their well-being.

Simple logic coupled with scientific evidence should instruct us that sexual intercourse by unmarried adolescents exposes them to unacceptable risks to their total well-being and to the well-being of our nation. There is no total antidote to immature sexual intercourse. A prescribed contraceptive may reduce the probability of unmarried parenthood, but it will not prevent 100% of all pregnancies, it will not prevent the risk of emotional harm, and it will not prevent the spread of sexually-transmitted disease which is at epidemic proportions. Furthermore, a secretly prescribed contraceptive strikes a serious blow against the adolescent's family relationships, and places that teenager at greater risk of emotional isolation form the very potential source of emotional sustenance for normaldevelopmental growth. In view of the option of parental involvement in social service delivery for adolescents, a general policy of secrecy from parents is a poor "second best" policy which poses its own unique risks of harm for the adolescent.

Note: These policy recommendations are the author's own conclusions and are not necessarily those of the Family Research Council or of the Department of Family and Child Development at Kansas State University.

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Senator **Denton**. Our next speaker, since he is a consultant to the Joseph P. Kennedy, Jr. Foundation, in my view, requires an extra introduction.

I am very pleased that you could be with us today, Dr. Bird. The Kennedy Foundation is headed by Mrs. Eunice Kennedy Shriver. During the development of the Community of Caring, a comprehensive services program for pregnant adolescents and adolescent parents, as well as the original Community of Caring curriculum, I am told that you made substantial input regarding the moral and ethical values highlighted throughout the curriculum, and have been very helpful in developing many of the classroom exercises now incorporated into the curriculum.

As you may well know, and as I will publicly acknowledge, I consider Mrs. Shriver a friend, and very definitely an ally, in this particular arena. I am buoyed by her support of my efforts here in this subcommittee, which has taken many forms.

I was one of the Senators who recently recommended her for the Presidential Medal of Freedom for her work both in the Special Olympics and in the field of adolescent pregnancy.

So in that context, and in respect for you yourself, sir, I welcome you this morning.

Dr. **Bird**. Thank you, Senator Denton.

I appreciate the opportunity to be here, and I want to also thank Karl Moor of your staff, for the assistance he has been in preparing these remarks.

Prior to writing the first draft of the "Community of Caring" curriculum for the Kennedy Foundation, I have been involved for about 15 years in family life and sex education curriculums development in this country, particularly in the religious sector. I did my doctoral dissertation in family life and sex education curriculums; a study of four major Protestant denominations, curriculums that have been developed over a 10-year period at three levels—for parents, for senior high youth, for junior high youth.

I have been actively involved in a number of courses in a range of places, teaching educators, teaching parents, and teaching teenagers. I have produced a book and written for various journals and magazines in this area.

Clearly, many of our teenagers have been casualties of the so-called sexual revolution. Ironically, they have often been doubly vulnerable. The combination of facing a psychosexual medical problem in the face of psychosocial immaturity on their part has placed them in double jeopardy, and the decision regarding parental involvement can weigh heavy and is an additional factor for them to handle.

I was struck in writing these remarks of the extent to which the adolescent is really doubly vulnerable with various of these kinds of medical problems, sexual problems, emotional problems to face on the one hand and with their level of immaturity, their striking out in independence, their acting out of various family problems, et cetera, on the other. This places them with a psychosocial problem of significant magnitude, very often a psychosexual problem, which is the crisis that then triggers their turning to various agencies. Whether or not the parent will finally become involved with them to any extent is our concern here.

A quotation that has made the rounds in the circle of those of us who work in the field of adolescent pregnancy comes from 1968, in the Journal of Marriage and Family, "The girl who has an illegitimate child at the age of 16 suddenly has 90 percent of her life's script written for her." It is difficult to know whether this scenario would become a kind of self-fulfilling prophecy or a form of sociological predestination. I am not certain. But I was very interested to learn, several years ago, that back in 1976, 8 years after this observation, Glen Elder, writing in the Forward to Dr. Furstenberg's book on "Unplanned Parenthood," made the pleasant observation that:

> By following the adolescent mothers into their early 20's, we discover how erroneous some of our impressions of early parenthood have been; in particular, the notion that bearing an unplanned child in adolescents leads inevitably to a life of deprivation. Diversity of histories and future prospects is one of the most striking findings of this study.

And Dr. Furstenberg documented well in that study some of the rather positive outcomes that can occur.

For many unmarried adolescent girls who become pregnant, while they may not be clear about the values by which they live up to that time, all of a sudden, they are confronted with life's ultimate values. I have been very struck by that.

In the clashes among values that these adolescents face, and in the clash between parents and adolescents, remarkable flexibility is possible, and remarkable reconciliations can take place. I have been involved first hand in a number of them.

Alex Haley contributed two paragraphs to our curriculum, and with the fascinating research he has done on families in this country and with the fame that is attached to his research and his experiences and his style, I think these insights are provocative:

> One thing which is absolute and universal among all of us human beings on this earth is that each of us is at birth a part of some family which goes back for many generations. We are a part of that blood lineage as much as anyone else is a part of theirs, and the pauper has quite as much ancestry as does the princess or the prince, and there is not one of us who has not a mother and a father both.
>
> For every child who is born, whether in a marriage or not, I think the mother can do nothing wiser than to make certain that her child is quickly exposed and made close to its available grandmothers, grandfathers, aunts, uncles, and cousins—for that child to develop with a stronger sense of family. So often this does not happen because the mother is embarrassed if there is no husband or loving father, and shrinks away from doing so when, if she did so, so often, she and the child might find most warm embrace.

With the range of sensitive subjects and problems associated with adolescent sexual behavior, the two most sensitive areas of public debate, it seems to me, concern sexual values and family involvement. With regard to the latter, one study of parental support for pregnant adolescents who had elected to carry to term discovered that nearly 90 percent of these early and midteen girls lived with a parent or a close relative. This is research which Dr. Furstenberg was involved in doing for us. And 1 year after delivery, 77 percent of these young mothers were still living with parents or a close relative.

An investigation of family life and sex education courses offered in U.S. public high schools—a major study that was done just a couple of years ago and reported in the literature—disclosed that schools that involve parents are significantly more likely to teach about controversial topics and social development topics, as well as to present a greater proportion of topics dealing with human reproduction and sexual values. In this survey, it is disclosed that 70 percent of those high schools investigated taught more values as a part of their curriculum, and 11 percent more of the educators thought that they ought to. So you are up at the 81 percentile believing that more values of some kind, however defined, ought to be integral to courses on family life and sex education in the public sector.

Interestingly, a 1979 Yankelovich, Skelly, and White survey found that 97 percent of parents with teenage children thought that teenagers should be taught about birth control and sexuality.

A 1981 NBC poll discovered that 75 percent of U.S. adults approved of sex education courses in school—and you have the latest Gallup poll, which you presented this morning, and that was rather fascinating, to see again the very high percentage of adults who believe that family life and sex education courses ought to be promoted in the public sector.

Family therapists, to turn to another sector of professional help, have long known that when an adolescent patient is admitted to therapy, he or she very likely needs to be seen in the context of the whole family system. And, as is well-known in family therapy—and I have been doing marriage and family therapy for about 7 years, now—in family therapy, when the adolescent it treated, the adolescent is known as the "identified patient," but it is the whole family system that is in need of treatment. Because the problem is located much more frequently in the lifestyle of the mother or the father or the conflict between them, or some other dimension of the family, the family is seen as a unit. So professional family therapists are most used to seeing the entire family when they see a dysfunctional adolescent.

That a supportive family network can adapt and can nurture an adolescent in crisis is well-known. What of the value conflicts in our pluralistic society? Unfortunately, in my judgment, not enough attention has been given to the integration of universal values in programs which deal with teenage problems.

I have written one chapter in a book that was published in the field of medical ethics several years ago on universal principles in biomedical ethics. I think that we well need to get our minds together and come up with universal principles of adolescent sexuality. And I think it could be done. Having read Sol Gordon, as well as a wide range of educators in human sexuality, there is a consensus of views, not just the rather easy ones of honesty and justice and caring and so forth. But if you talk to most informed educators, they see sexually active adolescents in the high school years as being incredibly unwise, and there is a strong consensus about that—if the adolescents would only realize that—even though we are there to serve them and to help them.

Themes such as justice, self-discipline, loyalty, courage, caring and trust belong in programs which deal with adolescent sexuality, whether the program is educational or therapeutic. Moral education should always accompany family life and sex education.

My experience with adolescents in such courses suggests that the overwhelming majority of questions raised by teenagers are value-laden. They do not serve up too frequently—although they obviously do—questions of biology, sociology, and so forth. But they ask the questions of "Should I . . .," "Is it wrong to . . .," and those kinds of questions are repeatedly found in their questions.

My style in doing sex education with teenagers is to give them all three-by-five cards and make them all write questions, because that way, they are not looking upon someone else's card, and if you leave it only to their raising a hand, they are too embarrassed, frequently. So I give them three-by-five cards, and to save Johnny looking at Joe's remarks to see what he is asking, I tell the ones who have no questions to write: "The sky is blue. The grass is green. Thanks for coming." So they are writing something, so that the other kids can write what they want to really write. And about 80 percent, typically, of the kids will have all kinds of questions, and they are just value-laden through and through. They are asking for advice, for counsel, for moral perspective.

Having heard the vehement voices at either end of the spectrum in our country on so many of these subjects, we often forget that there is a democratic consensus of values in the middle on many of these issues, and we have failed to make them clear, I think, to our adolescent population.

With the notable exceptions of unfit, physically abusive parents, situations of confidentiality, and life-threatening circumstances, it is likely that most mental health and family planning agencies would welcome parental involvement as appropriate. While informed debate may argue special cases, there should be little doubt that Government policies are designed to support the nurturance of stable family units.

I was reminded that other day in preparing this that the Preamble to our Constitution reminds us that our union is to "insure domestic tranquility," as well as to "secure the blessings of liberty to ourselves and our posterity." In a fascinating way, and in my judgment, since I have an interest in history, and in a long overdue way, this generation could do well to think much more clearly about our posterity, about their rights and their responsibilities, and our guidance and our support.

There are three concluding remarks that I wanted to make. The debate has raged in this country whether or not the home or the parents are the primary agency of education for family life and sex education. I do not think that there is any debate that they are the primary agency.

These are several important sequellae to this, though. First, in my judgment, they are not the only agency. They are the primary agency, but not the only agency.

Second, I have become more and more aware of the fact that parents in this country and parent organizations cannot have it both ways. They cannot argue that the parents are the primary responsibility and then provide no services that help them become educators. Most of our parents have not had sophisticated courses, or even elemental courses, in family life and sex education in their high school years or in their college program, whatever. They need all the aid they can get.

Another way in which parents cannot have it both ways—I have been active in Cub Scouts, in Boy Scouts, in leadership in our community; I have been a Little League coach; my wife has been Girl Scout adviser. We have both been struck by the fact—and these are in normally functioning, typical programs of community life—that parents are in absentia most of the time. You go to a Little League game, and the first game or two, the parents show up, and after that, Johnny hits a home run, and Dad is not there to see it, Mom is not there to see it. Parents are routinely absent in an awful lot of the regular functions of children and their lives. So then, all of a sudden, for parents to want to demand their rights to be very much involved with John or Jane when crises arise is a bit hypocritical when they have not spent the time with their children earlier. This is not to argue against our concerns here, but only to suggest that parents need to become much more sensitive about the time which they spend with their children under regular auspices and normal time, and the time they need to be confrontational or supportive in crisis.

And third and last of all, I have been very impressed with how much parents want help. I have been involved in a range of community- and church-related programs that have sought to educate parents. When professionals come and seek to speak to parent audiences alone about their role as a family life and sex educator, you meet with some of the most enthusiastic responses, some of the most gracious people, and some of the liveliest evenings you could ever imagine. So, if we could only get more of our mental health professionals and health educators to become involved with parent groups in the community, we might be much more on the right track.

Parents are very much interested in our help if we can find ways to support them in that.

Thank you.

Senator DENTON. Thank you, Dr. Bird.

[The prepared statement of Dr. Bird follows:]

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BEFORE

THE SUBCOMMITTEE ON FAMILY

AND HUMAN SERVICES

HEARING ON:

"PARENTAL INVOLVEMENT WITH THEIR ADOLESCENTS IN CRISIS:

THE FEDERAL GOVERNMENT'S RESPONSE"

THE U.S. SENATE COMMITTEE ON LABOR

AND HUMAN RESOURCES

FEBRUARY 24, 1984

ADOLESCENTS AT RISK AND PARENTAL INVOLVEMENT: ADOLESCENT SEXUALITY

Lewis P. Bird, Ph.D.

Into families are we born and by families are we buried. This is the experience of most Americans. Between these landmark events family networks may be incredibly supportive or unbelievably destructive. Transfixed in the shadows of this domestic pendulum are public policy makers, caught in the tensions between parent and child, traditional values and contemporary lifestyles, confidentiality and confrontation, nurturance and abuse.

As a nation we have witnessed an increase of premarital sexual intercourse amongst adolescent females ages 15-19 and living in metropolitan areas from 30% in 1971 through 43% in 1976 to 50% in 1979 (Research of Zelnik and Kantner of The Johns Hopkins University). By 1979, the first year measured by these investigators, 70 percent of 17-21-year-old males living in metropolitan areas reported having had premarital sexual activity. The average age at which young women begin intercourse is about 15.5 years for black adolescents and 16.4 years for white teenagers.

The proportion of all teenage women who have ever been pregnant before marriage increased also from 9 percent in 1971 through 13 percent in 1976 to 16 percent in 1979. While premarital pregnancies have been increasing, the proportion of adolescent females who will marry before the resolution of the pregnancy has been decreasing — falling from 33 percent in 1971 through 23 percent in 1976 to 16 percent in 1979.

Among adolescent females who remain unmarried, the proportion of premarital pregnancies resulting in live births declined from 67 percent in 1971 through 56 percent in 1976 to 49 percent in 1979. The proportion of premarital pregnancies terminating by induced abortions among the unmarried increased from 23 percent through 33 percent to 37 percent over these same three survey years.

Of cases of gonorrhea reported to the Centers for Disease Control in Atlanta for adolescents 15-19-years-old, 165,259 episodes were recorded in 1971 and 243,432 cases were reported in 1981 for an increase of 47 percent. (This may reflect better reporting methods and/or an increased incidence of disease.)

Clearly, many of our teenagers have been casualties of the "sexual revolution." Ironically, they have often been doubly vulnerable; the combination of facing a psychosexual medical problem in the face of psychosocial immaturity has placed them in double jeopardy. The decision regarding parental involvement can weigh heavy^

In 1968 one social scientist made an observation which was repeated by other professionals with considerable agreement: "The girl who has an illegitimate child at the age of 16 suddenly has 90 percent of her life's script written for her." It was difficult to know whether this scenario would become a kind of self-fulfilling prophecy or a form of sociological predestination. Fortunately, by 1976 more was known and another scholar could write:

Glen Elder

> By following the adolescent mothers into their early 20s, we discover how erroneous some of our impressions of early parenthood have been; in particular, the notion that bearing an unplanned child in adolescence leads inevitably to a life of deprivation. Diversity of histories and future prospects is one of the most striking findings of the study.

For many unmarried adolescent girls who become pregnant, while they may not be clear about the values by which they live, all of a sudden they are confronted with life's ultimate values. In the clashes among values and between parents and adolescents, remarkable flexibility is possible and remarkable reconciliations take place. As Alex Haley wrote in The Joseph P. Kennedy, Jr. Foundation curriculum, A Community of Caring:

> One thing which is absolute and universal among all of us human beings on this earth is that each of us is, at birth, a part of some family, which goes back for many generations; we are a part of that blood-lineage, as much as anyone else is a part of theirs. And the pauper has quite as much ancestry as does the princess or the prince. And there is not a one of us who has not a mother and a father both.
>
> For every child who is born, whether in a marriage or not, I think the mother can do nothing wiser than to make certain that her child is quickly exposed and made close to its available grandmothers, grandfathers, aunts, uncles, and cousins -- for that child to develop with a stronger sense of family. So often this does not happen because the mother is embarrassed if there is no husband or loving father, and shrinks away from doing so, when if she did so, so often she and the child would find most warm embrace.

With the range of sensitive subjects -- and problems -- associated with adolescent sexual behavior, the two most sensitive areas of public debate seem to concern sexual values and family involvement. One study of parental support for pregnant adolescents who had elected to carry to term discovered that nearly 90 percent of these early and mid-teen girls lived with a parent or close relative. And one year after delivery 77 percent of these young mothers were still living with parents or a close relative.

An investigation of family life and sex education courses offerred in U.S. public high schools disclosed that "schools that involve parents are significantly more likely to teach extensively about controversial topics and social development topics, as well as to present a greater proportion of topics dealing with human reproduction and sexual values." And a 1979 Yankelovich, Skelly and White survey found that 97 percent of parents with teenage children thought that teenagers should be taught about birth control and sexuality. A 1981 NBC poll discovered that 75 percent of U.S. adults approved of sex education courses in school. (A 1977 Gallup poll found that 77 percent of Americans supported family life and sex education in school.) Apparently parents of adolescents feel more strongly about this theme than the general adult population.

Family therapists have long known that when an adolescent patient is admitted to therapy, he or she will very likely need to be seen in the context of the family system. Therein the adolescent usually is known as the "identified patient," whereas the therapist sees the whole family system in need of treatment. A dysfunctional adolescent usually reflects some disturbance in the parents, apart from the organic or biochemical disorders. Mental health specialists typically involve the parents in adolescent problems.

That a supportive family network can adapt and nurture an adolescent in crisis is well-known. What of the value conflicts in our pluralistic society? Unfortunately, not enough attention has been given to the integration of universal values in programs which deal with teenage problems.

Are there universal values? I think so. Themes such as justice, self-discipline, loyalty, courage, caring and trust belong in programs which deal with adolescent sexuality, whether the program be educational or therapeutic. Moral education should always accompany family life and sex education. My experience with adolescents in such courses suggests that the overwhelming majority of questions raised by teenagers are value laden. They are asking for advice, for counsel, for moral perspective. Having heard the vehement voices at either end of the spectrum, we often forget that there is a democratic consensus of values in the middle on many issues.

With the notable exceptions of unfit, physically abusive parents, situations of confidentiality, and life-threatening circumstances, it is likely that most mental health and family planning agencies would welcome parental involvement as is appropriate. While informed debate may argue special cases, there should be little doubt that government policies are designed to support the nurturance of stable family units.

Since parental support is essential to the healthy psychosocial and psychosexual maturation of adolescents and since even parents in dysfunctional families often discover more adequate ways of parenting, I would recommend that any federally funded program involved with adolescent sexuality which denigrates the responsible authority of parents, the proper role of parents and the traditional values of parents, whether in its written or audio-visual materials, be revised.

Likewise, since the vast majority of family life and sex education authorities as well as medical educators — whatever their personal value system may be — consider adolescent intercourse amongst the unmarried in the junior high school and senior high school years to be most unwise, I would recommend that any federally funded programs involved with adolescent sexuality which either seem to encourage sexual intercourse or seek to appear to be "value free" with respect to this expression of human sexuality, whether in audio-visual or written materials, be revised.

The preamble to the Constitution of the United States argued that our union should "insure domestic Tranquility" as well as "secure the Blessings of Liberty to ourselves and our Posterity." In a fascinating way — long overdue — this generation could do well to think more clearly about our Posterity, their rights and their responsibilities along with our guidance and our support.

Senator **Denton**. Thank you, Dr. Bird.

I guess, as chairman of this subcommittee, I should announce to this audience that I am not against sex education, because the things that have been said about me in some of the media—enough of the media to penetrate into my home State, at least to the newspaper which operates in the capital of my home State, recently—praised me for acknowledging that I am not against sex education.

I want you to know that before I came here, for years, I was involved in this. I formed a private foundation called the Coalition for Decency. I was given many awards by people in sex education. I was made the principal speaker many times in symposia on the subject. And one newspaper chose to, in a speech that I committed to make in the Tidewater Conference on the Family on the subject of sex education, wrote a long article, insulting my State on having already elected me as the Republican nominee, because I was running on a sex platform. Well, I was not there to talk about politics. I had been invited 6 months previously to talk about sex education. My son answered the letter, and they did print it.

I want you to know that I agree that parents should be involved. I lament that in too many cases, they are not permitted to be involved. I admit that they have a tremendous awkwardness about the problem, sometimes an absolute carelessness about it. And I am aware of Covenant House in New York, and was surprised to learn that most of those kids are not runaway kids, but are kickout kids. So, parents are not the be-all and end-all. They are individuals, like adolescents are, and they need to have a greater sense of responsibility as I do as a legislator, as I did as a naval officer, as I do as a citizen. We all need that. No question about it.

The question before this subcommittee today is whether or not it is good or bad for parents to be involved in the sexual education of their children, and more specifically, into such things as they should become involved at a time of crisis when, by their own inadequacy or by their own kid's failure to respond, or by whatever reason. Up to that point, they may have been ineffective. But at the point of decision, regarding a commitment which, as you agreed is rather important, not only morally but psychologically, physiologically, and not too many have mentioned it, but there is a third party involved—the little person that might come on the scene as a result of this. If there is an Almighty—and I believe there is—I do not believe that there was some kind of a haphazard explosion, where organisms were present, and therefore there was a source of life. But who made the organisms? And by what genius was conception of a human being created?

So I acknowledge I have the bias of a belief in a God. However, I do not think that such a bias or belief is required to come to the kind of consensus that Dr. Bird referred to. It is in that context, that I acknowledge that others may be atheistic, may have honest or dishonest disagreements of opinion with me. Others you can question whether mine are honest or not. But nonetheless, I believe there is a commonality of belief that is achievable by a goodwill effort to work toward it. I do not see the goodwill effort. That is, to me, the greatest problem. That is why I came up with this—and not only this problem. For example, the lack of bipartisanship in our foreign policy, which we once had, do not have now, to our great peril and to our suffering economically, in ways that this Nation has not even begun to question.

So I do not wish to be antagonistic toward, say, feminists—even toward Planned Parenthood, Dr. Furstenburg, or the Alan Gutmacher Institute.

I do have sincere differences of opinion about the way sex education has involved and developed in that community. I agree that some of the movies which I have seen and helped convince my colleagues about the need for the adolescent family life bills, are probably not harmful to some kid who has been committed to years for this or that, and has no parents, et cetera. My concern is that there is variety among children watching those films, and I think there should be consideration given to that. I hope you can think more deeply. I shall, I promise you.

The Alan Gutmacher Institute has been the principal source of surveys on this subject. I can promise you this, if this Institute does not change by re-thinking opinions such as "the kids are going to do it no matter whether the parents get in it at all, and therefore it is inconsequential to involve the parents," then I am going to try to bring about some other sources of surveys on this subject to come up with other issues and questions and analyses.

So I do not want to be dishonest about how I feel about it. But I feel that many of the people involved in Planned Parenthood are sincere—all, I could grant—and that different Planned Parenthood clinics operate differently throughout the United States. I know that. But we do have issues here which affect our survival as a nation.

H.G. Wells says agriculture and family are the two requisites of civilization. Bettelheim says that any nation which relaxes its sexual mores has passed its peak of power.

We are not the judges of this. History is the judge of this. It is back there; it is self-evident. And when our Founding Fathers said, "We hold these truths to be self-evident," they did not even question that the family should be the primary unit. In the fifties, things were not just hidden, because we did not have that kind of outbreak of Herpes, or AIDS, and we did not have suicide as the second cause of death among teenagers. It is different today. And I do not blame it on Government policy in this area. I blame it on our generally not passing the test of coping with prosperity. That is what I blame it on—us, as a people, we are at fault. And this takes effect in what the media portrays, what academe portrays, what Government policy portrays, and I am concerned about all, as I am concerned about my own morality and my own honesty in facing what I should do and not do in life.

I would like for you all to just discuss among yourselves the differences among you. There was quite a set of differences. Would any of you care—because I defer to all four of you as men who are more versed in this, in spite of my own involvement, which is considerable. I think all four of you each probably have had more experience, so have at one another, or have at me.

Dr. **Furstenberg**. Well, before we discuss the differences, it might be well to dwell on the similaries. I wholeheartedly agree with 90 percent of what Dr. Bird said, and I think most providers of family planning services would very strongly endorse the kind of statement that he made.

The one area of disagreement, I guess, would be about my own work—and maybe he would recharacterize it. I do not think that early childbearing has pleasant consequences, but I think some people, some young women, land on their feet, and it is very important to know why and how that happens. And one of the major sources of support is the family.

But I think there was a great deal of consensus, especially at the two ends of the table here, about the need for family involvement and I think among all of us. And I do not think that there is any disagreement about the importance of involving the family as an active and a principal agent of sexual training. I think the question is how to do that, and whether in doing that, we do it at the exclusion of also providing support for teenagers who become sexually active, to prevent pregnancy. And I think that may be where there is more issue.

As to the changes between now and the fifties, there is no question that there has been more sexual activity, and that there was an increase during the seventies. But I think it can be well-documented that, really, throughout the 20th century, really, beginning after World War I, perhaps even earlier, there was a good deal of sexual activity in American society. And in the fifties, we know very well that half of all marriages were teenage marriages, and more than half of those marriages were preceded by a pregnancy. So it suggests that there was a lot of sexual activity then. We have never been a nation that has conformed to the ideal of of chastity, although it has long remained an ideal. I think what has happened in recent years is that there has been controversy over that ideal and what to do about it. And I think there are honest disagreements among those of us on the panel here——

Senator **Denton**. Well, your own statement about that—and I do not mean to interrupt—does contradict the pounding on the table of counselors from Planned Parenthood, who say that they insist on total confidentiality, and the movies and literature which imply that the parents should not be listened to because they are old-fashioned.

Dr. **Furstenberg**. I think you may have been occupied when I mentioned that the survey that I had conducted in 1981 showed that about 50 percent of all family planning providers were currently delivering programs to parents in a variety of forms.

As a matter of fact, Planned Parenthood was doing better than the health departments——

Senator **Denton**. But couldn't you permit them in on the counseling, the sex counseling to the child? That is what the issue has been.

Dr. **Furstenberg**. Well, most family planning programs do not do extensive counseling. They share your view that a lot of that counseling ought to be done in the home. And at best, I think we can work out——

Senator **Denton**. I did not say that. I did not even say that. I have never said that I think most of it should be done in the home. I think it would be desirable if it could be, but I have not seen any demonstration that it has been or can be. I just say that when it is conducted, that the parents ought to be able to hear what is said and contribute to what is said.

Dr. **Furstenberg**. Well, I certainly agree that parents ought to have a role, and a greater role, than currently exists, and I think we are moving toward that—I think that is the consensus. There may be people who disagree with it. But as I indicated in the survey—this was several years ago—the majority of family planning providers agree that there ought to be greater parental participation and are developing programs to implement that goal.

Senator **Denton**. Dr. Rekers?

Dr. **Rekers**. Well, I see one of the differences between my view and Dr. Furstenberg's would be what I sensed in his written and oral testimony as a kind of fatalism, assuming that there is very little, if anything, that could be done to convince adolescents or work with them to be abstinent.

At one point on page 4, he said that in the data he was referring to, even when discussions do occur in the home * * * nor do they seem to constrain teenagers' sexual activity.

At another point on page 5, he talked about the parents seeming to be resigned to the fact that their views could not defer adolescent sexual activity, even though the parents would prefer that.

And another point, later, he mentioned that his opinion was that if the teenagers had parents notified, on page 8, "hardly any would stop having sex."

I think there is a research question here, and that is, what is the sample that is being studied? If your real desire is to find how can we help these teenagers to be abstinent, perhaps the most pertinent families to study are not the families with the kind of communication that is going on already with of the child in crisis coming to the clinic. What we need—and we need a lot of research addressed to this—is some study of those millions of parents who have teenagers who do restrain themselves from sexual activity throughout their adolescence. We need to study what are they doing; how are their families different in their communication patterns, and family relationships and moral teachings. It is working for millions of adolescents that never get pregnant. And what are they doing different? That would be the proper population to sample, in terms of research, if your real question is "can communication within the family help adolescents defer sexual activity."

It appears that the data source he is drawing from is limited to primarily crisis cases only. By looking only at a skewed pathological end of the continuum, and by not looking at the healthy, adaptive families, he is led to an unrealistically pessimistic conclusion of throwing up his hands, saying, "What can we do about it? We might as well give them contraceptives." When I say he is looking at the "pathological" end of the continuum, I am not referring to psychological disorder necessarily, although some may be phsychologically distrubed. Instead I am referring to the sexally active adolescents who are often rebelling against their parents in ways not representative of the entire population of adolescent and their families.

So, I think that perhaps Federal legislation could be written to mandate more research on what are the strong, healthy families are doing in those cases where the teenagers are staying out of trouble, and then see if we can translate those things as professionals to help these other problem families do the kind of communication that is going on in those adoptive families. And I am optimistic, looking already at some of the research on strong, healthy families, that this next step could be taken. We do not have to throw up our arms and say, "The only thing we can do is dispense contraceptives in secret."

The second point, I think, where we differ, is——

Dr. **Furstenberg**. Could I answer that, and then maybe you could go on to the second point?

Dr. **Rekers**. OK.

Dr. **Furstenberg**. I quite agree, we want research on a broad spectrum of families. The second figure that I mentioned was from a nationally representative sample of adolescents. Under a grant from the Office of Adolescent Pregnancy, I am now currently looking into the sources of early sexual activity. And I quite agree that that is a high priority we need to know. I think I share the views of the panel, that it is not desirable for teenagers to begin to have sex at 13, 14, 15, and that we ought to be working toward postponing the onset of sexual activity. I do not believe, however, that all teenagers who come into family planning clinics are a pathological segment of the population, as you have just indicated. We are dealing with a huge population of teenagers, and they are very diverse. They range from 13-year-old kids who are incredibly confused to 17- or 18-year-old college students. And I think we have got to take into account that this is a very diverse population, and we need diverse strategies for dealing with them.

Dr. **Rekers**. My question would be: What would you do if you were an advisor to a federally funded agency—what are all the things that you would try first, before secretly dispensing contraceptives to an adolescent?

Senator **Denton**. Well, I can show you some of them, and that is what got me into this—I do have adolescent pregnancy under my jurisdiction formally in the Government, and I am required to address the problem. When I looked at the most popular movie of that time, dispensed by Planned Parenthood, I was not edified by the thrust of the program, nor were any of the other Senators who saw it, not all of whom are conservative. I would be delighted if the four of you were to see this film, and then I would be further delighted if Dr. Furstenberg, whose words certainly do not agree with the thrust of the film, which leaves the parents out, and there is reference to that—they are, in fact, deliberately doing so—and not listening to the parent about it. There is more than just value -free. If you took a vote from 100 citizens looking at it, they would say, "Oh, no. They are pushing them toward sex."

I would be delighted were you to make sure that such programs which do not appear to be in consonance with your own views, be taken out of that system.

Dr. **Furstenberg**. I have advocated in both speeches and in writing that we develop funds that supplement the title X funding to promote parental participation and family involvement. I think we need greater parent education. That is one of the things that I would start with. And I would not restrict the job of parental education to the schools or to the churches or to any segment of the community. I would have a partnership between many of the agencies that are now concerned with the problem.

But I think in response to your question, Dr. Rekers, that what you want to do is develop a lifelong strategy. You do not want to deal with people at times of crisis—if you call crisis—and it is—coming into a clinic for the first time when you have been having intercourse for a year and a half, and you think you are pregnant. That is not the ideal time to begin anything. So, we have to start earlier, and we have to have a partnership with many of the community agencies.

Senator DENTON. May I ask Mr. Potter to put in his word, because he, though not being a researcher, does have experience in actually dealing with these problems, for his reaction as to what has been said today.

Mr. POTTER. Well, I am appalled by the amount of information I am hearing here today.

Let me give you, I think, a little grassroots perspective of what the kids are saying out there, and realizing that I am from the west coast and fairly limited, but realizing also that I have been at it 11 years, so I am starting to get up there in years of experience.

I am convinced that the kids are really struggling with their interpersonal relationships. I think that their relationships as they develop with each other are very powerful in their lives, and they are very meaningful in their lives. And I think that as they struggle with this, they try to deal with the fact of keeping a boyfriend or a girlfriend, keeping them as an associate of sorts or as a companion of sorts. I think they are trying to struggle with that feeling of holding onto this individual, as well as struggling with their feelings of "I know, basically, I am doing the wrong thing in terms of my sexual activity." They have put themselves in a very, very difficult situation.

Just Thursday, as I was writing up the final part of my text, in walked a girl who wanted to talk about these problems and the struggle that she is having internally with herself as to what direction to go. I simply get back to my other statement, Senator, that we as adults have a responsibility to serve as role models, and we need to put that ideal out in front of those kids, despite how difficult that ideal might seem to be in terms of reaching, and challenge these kids with that.

Again, referring to Eunice Shriver, nowhere do I hear that challenge being made out in the public, out in the real world, to these kids, and I have a tendency to agree with her. So that challenge of trying to instigate a lifestyle of avoidance of premarital activity until the relationships are established, until the psychological and sociological development has occurred, that can only be a positive in their life if they have established that relationship.

Senator DENTON. A key observation. It seems to me it does agree with something Dr. Bird said about a number of qualities, you might say, almost values, which are relevant and important to any effort to inculcate a perspective on this situation. And yet I have not seen that, frankly, except as a denial on the part of Planned Parenthood. They say it should be value free, I believe. And I maintain from what I have seen that it does not even reach that level of morality, and I do not mean to be condescending. I believe that that would be their own self-assertion.

There may be some clinics that are not that way, but the ones that have come before me, and what I have seen, I would have to characterize that way.

Mr. **Potter**. Senator, I would like to address myself to that just briefly. I think it is impossible to teach value-free sex education. I have tried it. I saw the detrimental effects. I saw kids walking out there with big question marks and a lot of ignorance.

I also question how you can possibly teach sex safely to adults. There is nothing safe about sex, in terms of involvement—not spiritually, not psychologically, not socially. So we need to continue to strive and, as I say, hang that ideal out in front of them and allow them to go after it.

Senator **Denton**. Well, thank you very much, gentlemen. I hope that we can establish at least a belief that we want to be objective in this, that we want to be intellectually honest in it and mutually respectful of one another.

I can get angry at times, which I later repent, but I do not have any feelings of animosity toward any human being I know. I just want us to go ahead and try to fulfill what our Founding Fathers, in a stroke of genius laid down—even the Encyclopedia Brittanica—although they mock the military aspects of the Revolution—speaks in deeply respectful terms of the genius of those gentlemen, who wrote the set of principles which we are dropping, I am afraid, at an alarming rate, and which were responsible for our greatness.

I would like for us to work together in the recovery of that. I think we have sunk away from it.

Thank you very much.

Senator **Denton**. We will now call our last panel.

I will say that I am sorry about the lateness of the hour, and I thank you all for hanging in here with us.

We will now hear from John W. Nields, Esq., who is appearing in behalf of the National Family Planning and Reproductive Health Association, Inc., or NFPRHA.

Mr. Grover Rees prepared an amicus brief in the parental notification suit.

I welcome both of you gentlemen, and I will ask for Mr. Nields to go ahead with his statement.

STATEMENT OF JOHN W. NIELDS, ESQ., ON BEHALF OF THE NATIONAL FAMILY PLANNING AND REPRODUCTIVE HEALTH ASSOCIATION, INC., AND GROVER REES, ESQ., ASSISTANT PROFESSOR OF LAW, UNIVERSITY OF TEXAS

Mr. **Nields**. Good afternoon, Mr. Chairman.

My name is John Nields. I am a member of the law firm of Howrey & Simon, here in Washington, DC, and I have recently represented the National Family Planning and Reproductive Health Association in its successful lawsuit seeking to declare invalid the mandatory parental notification regulations which were promulgated by the Department of Health and Human Services.

It is a considerable honor, I may say, Mr. Chairman, to be asked to come here and address this Subcommittee on NFPRHA and its many member organizations who, as the committee undoubtedly knows, are the recipients of some 75 percent of the funds that are dispensed under title X.

On a personal note, I appreciate the manner in which these hearings are being conducted.

NFPRHA and its member organizations strongly support family involvement in sexual decisions by teenagers. Equally strongly, however, NFPRHA and its member organizations believe that good parenting, good communication between parent and child, cannot be achieved by mandatory Federal legislation, and further, believe strongly that a requirement that title X clinics notify parents of children, adolescents, who are receiving family planning services would have the effect of keeping some approximately 100,000 teenagers a year away from the family planning clinics and would result in a substantial increase in adolescent pregnancies, births, and abortions.

I would like, with that in mind, to divide my testimony this afternoon into three categories—first, existing law; second, the power of Congress to change that law consistent with the Federal Constitution, and third, the question of whether, to the extent that the Congress has such power, we believe it would be wise for it to exercise it.

First, on the subject of existing law. Two Federal courts of appeals have in the recent past held invalid and struck down this mandatory parental notification regulation, promulgated by the administration. The reason that the courts gave for invalidating this regulation is that the courts believed the regulation to be squarely contrary to the clearly expressed will of the U.S. Congress throughout the history of title X.

The courts took note of the fact that in 1978, Congress had information in front of it that 1 million, approximately, teenagers were suffering unintended pregnancies every year. These resulted in over 300,000 abortions and over 600,000 births. The cost to the Federal Government in welfare alone was $4.6 billion for the families into which those children were born. The cost to the families themselves and the individuals involved were beyond calculation. Congress viewed this as a national emergency. And the Court took note of legislative history showing that Congress believed that promises of confidentiality to the teenagers were essential if they were to be induced to come to the title X clinics and receive needed contraceptive protection, and that Congress therefore rejected all proposals which would have required parental notice or parental consent.

As I say, the courts consequently viewed the regulation as being contrary to the expressed will of Congress; they enjoined the regulation, and the injunctions have become final as a result of the administration's decision not to seek review in the Supreme Court of the United States. Consequently, those decisions as of now are the law of the land.

Now, of course, normally, Congress has the absolute power to change the law of the land. But I think we would all agree that Congress may not change the law of the land in such a way that it would violate the U.S. Constitution.

It seems fairly clear, based on cases decided in the courts, that they would hold invalid a mandatory parental notice requirement, legislative requirement, insofar as it applied to minors denominated mature, regardless of chronological age.

There have been recent court decisions striking down such a requirement as to mature minors, in the context of privately funded clinics and hospitals, and in the context of both abortions and provision of contraceptive services.

Relying on this recent line of cases, a Utah Federal court within the last couple of months held—and I will quote—"The State may not impose a blanket parental notification requirement on minors seeking to exercise their constitutionally protected right to decide whether to bear or to beget a child by using contraceptives."

Now, it is clear as a matter of constitutional law that Congress need not fund either abortions or contraceptive services at all. And title X could be repealed entirely consistent with the Constitution. However, there is a line of cases which hold that although Congress is not required to confer a benefit, if it chooses to confer that benefit, it may not attach an unconstitutional condition on it.

The courts, having already ruled that a parental notification requirement would be an unconstitutional condition if applied to a privately funded clinic, it would appear that it would be equally unconstitutional if applied to a clinic which received some Federal funds.

Therefore, there is grave doubt whether a parental notification requirement as to mature minors would be sustained by the courts in response to a challenge under the Federal Constitution.

Senator DENTON. Could you define "mature minor"?

Mr. NIELDS. No, Mr. Chairman, I cannot define a "mature minor." But it is a question which the courts—and at the moment, I am simply describing what the courts have said—it is a question which the courts require to be addressed and to be decided. And the one thing that is clear is that it is not a question of are you 17 or 18 or 16 or 15 or 14; it is a case-by-case decision that needs to be made. That is what the law says.

I would like to continue, if I may, and address the question—assuming that Congress has the power, or to the extent that it has the power, would it be wise for Congress to exercise it to change the law.

Senator DENTON. Now, let me make sure I understand the point you made. The court ruled on the basis of not violating the constitutional right of the mature minor to use contraceptives to avoid being pregnant—is that generally what you said?

Mr. NIELDS. Yes.

Senator DENTON. And then, you went on to say that these contraceptives need not be provided by the Government?

Mr. NIELDS. True.

Senator DENTON. Nobody questions free will, and you are not going to crush the head of a 15-year-old girl or boy who decides that she or he is going to fornicate. I am not in favor of that. But I do—I will reserve my comments until later.

Mr. NIELDS. I appreciate that, Mr. Chairman.

As I have already indicated NFPRHA believes that it would be unwise to adopt by legislation a requirement that the title X clinics notify parents of teenagers receiving contraceptive services. That judgment is based on two propositions of fact, which I believe are not disputed.

First, there are some approximately 1 million teenagers each year who suffer unintended pregnancies now—that is an existing fact.

Second, that fact is not caused by title X, or by anything that the Federal Government is doing. It is something that has happened in our society independent of title X. And the statistics show that the overwhelming majority of teenagers who come to title X clinics have already been sexually active for a substantial period of time——

Senator Denton. The majority, you say?

Mr. Nields [continuing]. The overwhelming majority. Presumably, they have been becoming pregnant, having sex, without parental involvement, without parental consultation, and it would seem common sense, and the studies also corroborate this, that if a parental notification requirement were engrafted onto the law, many teenagers who are now induced to come in would stay away, and they would continue to have sex, and they would become pregnant.

That is the basis of NFPRHA's opposition to such a requirement, Mr. Chairman, and it is shared by, so far as we know, virtually every group that has hands-on experience on this subject.

Forty State governments commented on the mandatory parental notification regulations while it was in the proposed stage. Every single one of those governments was against it.

Senator Denton. State governments?

Mr. Nields. State governments.

Senator Denton. Manifested by what authority in the government of the State—the department of health or social services, right?

Mr. Nields. In some cases, it was that. In many cases, it was the Governor. Governor Buzbee of Georgia, for example, submitted the following comment, and I quote: "Our position is a realistic one. Withholding such contraceptive information and devices"——

Senator Denton. I will grant that he made a statement to that effect. I can submit a number of others, like from the Governor of my own State of Alabama, which would counter that. So I would not mind polling the Governors on this subject. But we have had Gallup poll the Nation on this subject, and people do not agree with that. The governments you say, in the manifestations that you have given, have stated differently.

I do not want to get into the argument, and your time has more than expired. I do not mean to be unfair to either one of you, and I would ask you to summarize in a minute or so, if you can, so Mr. Rees can be heard.

Mr. Nields. Thank you, Mr. Chairman.

I do wish to summarize, and my summary is as follows. Some of this is based on testimony which has been submitted in writing, and I presume will be made part of the record, which I have not delivered orally.

Senator Denton. Your full statement will be included in the record.

Mr. Nields. Thank you very much.

We believe that in order for Congress to pass a statute that would require parental notice, it would have to first reject the practice in the private medical community, which is not to give parental notice. Second, it would have to reject the views of every single State government that commented on such a regulation, administratively. Third, it would have to reject the views of virtually every, single major medical association in the country, from the AMA to the American Academy of Adolescent Medicine, who also commented on these regulations. Fourth, it would have to reject the prior decision of Congress throughout the history of title X. And, fifth, it would have to seriously risk passing a statute that violates the Federal Constitution. And finally, we believe it would have to pass a regulation which would have the effect of substantially increasing the numbers of pregnancies, births, and abortions which would result to teens.

Thank you very much, Mr. Chairman.

Senator DENTON. Thank you, Mr. Nields.

[The prepared statement of Mr. Nields follows:]

NFPRHA
National Family Planning
and Reproductive Health Association, Inc.

TESTIMONY OF

JOHN W. NIELDS, JR., ESQ.

BEFORE THE

SUBCOMMITTEE ON FAMILY AND HUMAN SERVICES

COMMITTEE ON LABOR AND HUMAN RESOURCES

FEBRUARY 24, 1984

1110 Vermont Avenue, N.W., Washington, D.C. 20005 (202) 467-4767

Mr. Chairman and Members of the Subcommittee:

My name is John W. Nields, and I am a partner with the Washington, D.C. law firm of Howrey & Simon. I appear here today, at your request, on behalf of the National Family Planning and Reproductive Health Association, Inc. ("NFPRHA"). I recently represented NFPRHA in litigation challenging the mandatory parental notification regulations promulgated under the national family planning program, Title X of the Public Health Service Act, by the Secretary of the Department of Health and Human Services.

NFPRHA is a national non-profit corporation, originally conceived as a membership organization made up exclusively of agencies receiving Title X funds. NFPRHA's membership is no longer limited in this fashion, but its focus continues to be on Title X issues and the overwhelming majority of its institutional members continue to be Title X recipients. Included in NFPRHA's membership are representatives of over 75% of the grantees receiving direct grants under Title X. In fiscal year 1982, NFPRHA's members received approximately 82% of the total funds available for family planning services under Title X. NFPRHA has over 1300 members, including state, county and city health departments, Planned Parenthood Federation of America affiliates, hospital-based clinics, umbrella family planning councils, independent free-standing clinics, and other family planning organizations and providers, and consumers of family planning services. These members utilize Title X funds to provide and coordinate a wide range of reproductive health care services, including contraceptive services, for adults and minor patients.

I appreciate the opportunity to appear before the Subcommittee today, on behalf of these many concerned groups and citizens, in support of Congress' existing policy of providing teenagers access to family planning services under assurances of confidentiality. I emphasize at the outset that all of these groups believe that the family is one of the most, if not the most, important institution in American society; and strongly support Congress' existing policy of encouraging parental involvement in family planning decisions. However, these groups also believe that good parenting and good communication within a family cannot be achieved through mandatory federal legislation; and that a requirement of parental notice or consent, in connection with the provision of family planning services, would only deter teenagers from seeking family planning services and would result in a large increase in the numbers of teenage pregnancies, abortions and unintended births with which Congress has been so vitally concerned over the last decade.

I plan in my testimony to discuss three issues. First, I will discuss the federal law as it exists today with respect to parental involvement in family planning decisions by teenagers. Second, I will discuss the question whether Congress has the power to change the law consistent with the United States Constitution. Third, I will discuss the policy issues raised by any proposed legal requirement of parental involvement in the family planning decisions of teenagers, and the treatment of these issues by the states.

1. *Existing Law*

As this Subcommittee well knows, Congress, under Title X, has funded family planning services for all women in need of them since 1970, when Title X was first enacted. Under existing law, clinics receiving Title X funds must encourage *teenagers* receiving contraceptive services to consult their families. However, clinics receiving Title X funds must honor a teenage patient's request for confidentiality and may not notify a teenager's parent *directly* of the teenager's request for family planning services. These principles have been established by clearly expressed legislative intent, and have been declared as law by two United States Courts of Appeals.[1]

As enacted in 1970, Title X did not expressly refer to adolescents. They were, however, intended to be included among the groups served, and they received services under assurances of confidentiality, just as adults did. In 1978, however,

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[1] *Planned Parenthood Federation of America, Inc. v. Heckler*, 712 F.2d 650 (D.C. Cir. 1983); *New York v. Heckler*, 719 F.2d 1191 (2d Cir. 1983).

Congress acquired evidence that there was a virtual epidemic of teenage pregnancies requiring emergency measures. Congress had before it evidence that approximately 1,000,000 teenagers suffered unintended pregnancies each year, resulting in over 300,000 abortions and over 600,000 unintended births. The annual cost in welfare alone for the families into which these babies were born was, as one congressman noted, "$4 billion -- not million -- $4.650 billion."[8] The additional cost in terms of broken lives of young women and their inadequately cared for babies is, of course, beyond calculation.

Congress set about to remedy the situation immediately. It amended Title X so that it expressly covered "adolescents," and made the availability of contraceptives to teenagers a top priority under Title X.[9] Congress believed that assurances of confidentiality to the adolescent were essential to the success of the effort to curb the epidemic of teenage pregnancies and abortions. Believing that any requirement of parental notice or consent would frighten many of the teenagers from the clinics, Congress rejected all efforts to impose such requirements. Thus, in 1978, a proposed amendment (the Volkmer Amendment), which would have required parental notice, was voted down.

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[8] 124 Cong. Rec. 35,621 (1978) (statement of Rep. Rogers).

[9] Congress was not thereby condoning teenage sexual activity. As one congressman put it, the 1978 amendment:

> should not be construed as condoning adolescent sexual activity. Rather it deals with reality and simply attempts to provide young people with the information necessary to avoid pregnancy . . . . We cannot decrie [sic] abortions and at the same time fail to provide counseling and other services which will prevent unwanted pregnancies.

Id. at 31,248 (statement of Rep. Whalen) (emphasis added).

In a letter to Congress opposing the proposed parental notification requirement, the Department of Health, Education and Welfare stated:

> [E]nactment of . . . [this amendment] would undermine the national effort to alleviate the growing problem of teenage pregnancy in this country . . . . We all agree it is important to prevent unwanted teenage pregnancies and the program authorized under Title X is the cornerstone of our effort in this area.
>
> . . . We are determined to ensure that our policies encourage providers of contraceptive services to promote family involvement. At the same time, we think it is necessary to protect the confidentiality of those teenagers who seek the use of contraceptives . . . . [E]xisting data do suggest that any procedure which requires informing parents that their children are using contraceptives will deter adolescents from using contraceptives, but will not deter sexual activity.[*]

Similarly, Congressman Rogers, the floor sponsor of the bill which Volkmer sought to amend, himself declared:

> MR. ROGERS: Mr. Chairman, I reluctantly must rise the oppose the amendment . . . .

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[*] Letter from Acting Secretary of Health, Education and Welfare Hale Champion to Representative Paul S. Rogers (Sept. 25, 1978).

> I agree that family planning programs shoud encourage adolescents to discuss their sexual actiivities with their parents, but many simply will not come in if we require such a discussion. And what will happen to them? The risk becoming pregnant and we risk spending $4.5 billion a year in welfare costs for adolescent mothers and their dependent children.
>
> . . . [T]he committee has thought this through and I would urge the Members to be practical, to be realistic, and to vote down this amendment.[*]

Representative Richardson Preyer (D-N.C.) spoke of the "tragedy" of "unwanted children" born to "teenage girls with no financial means":

> MR. PREYER: Mr. Chairman, I rise in opposition to the Volkmer amendment. I believe very strongly that, if we are to encourage family planning and a reduction in teenage pregnancy, we ought to devise legislation which will accomplish our purpose.
>
> Family planning is a sensible, logical way to avoid the unhappy consequences of abortion on the one hand and unwanted children on the other. . . .
>
> . . . .
>
> If we are going to put some clout behind the intent of the legislation, we must think first and foremost about what can be done to prevent teenager pregnancies. . . .
>
> And if these teenagers . . . have to seek parental consent for contraception, the whole intent of this legislation will be undermined.
>
> . . . .

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[*] 124 Cong. Rec. 37,044 (1978) (statement of Rep. Rogers) (emphasis added).

> I do not condone children keeping secrets from parents. But this is not the issue here. . . .
>
> I urge a "no" vote on the Volkmer amendment.[6]

The following year, Congress rejected efforts to impose a parental *consent* requirement on the provision of family planning services under the Medicaid program.[7] In opposing the proposed amendment, Congressman Henry Waxman pointed out "the reality of the situation that many children, teenagers, are sexually active without parental consent, and that they are going to be discouraged from going to family planning clinics if in fact there is this requirement of parental consent "[8] When the same amendment was proposed again a few days later, Congressman Tim Lee Carter (R-Ky.) spoke against it:

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[6] *Id.* at 37,047 (statement of Rep. Preyer) (emphasis added). Congressman Ted Weiss (D-N.Y.) spoke in a similar vein in opposition to amendments to the Title X bill being discussed:

> I do not understand how those who decry abortion can at the same time fail to provide counseling and educational services which are the very things able to help prevent an unwanted pregnancy.
>
> I believe that passage of these amendments would . . . [result in] an increase of unplanned and unwanted pregnancies and thus a rise, rather than a decrease, in the incidence of abortion. . . .

Id. at 37,048 (statement of Rep. Weiss).

[7] Title XIX of the Social Security Amendments of 1972, § 299E(b), 42 U.S.C. § 1396d(a)(4)(C) (1976). *See* 125 Cong. Rec. H11,641 (daily ed. Dec. 6, 1979). Both the Medicaid program and the Aid to Families with Dependent Children program, 42 U.S.C. § 602(a)(15)(A) (1976), require the provision of confidential family planning services to sexually active minors that request them.

> Actually, of the youngsters in our country who are 15 years old and younger, about one-fifth of them are sexually active. To prevent them from getting needed contraceptives beggars the imagination. Defeat of this amendment would save these children from unwanted pregnancies. It would save the country from unnecessary abortions which might occur as well.[9]

The proposed amendment was then defeated by a roll call vote.[10]

As you know, in 1981, Congress added language to the Title X statute, consistent with existing administrative practice, to "encourage . . . family involvement." Then, in 1983, the Administration sought by regulation to impose virtually the same parental notice requirement that Congress had voted down in 1978. The courts have now struck down the regulations, in suits brought by NFPRHA and others, as being clearly contrary to Congress' intent.[11] The courts noted that nothing had occurred since 1978 to indicate that Congress had changed its mind.[12]

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[8] 125 Cong. Rec. H11,641 (daily ed. Dec. 6, 1979) (statement of Rep. Waxman).

[9] 125 Cong. Rec. H11,786 (daily ed. Dec. 11, 1979) (statement of Rep. Carter).

[10] Id. at H11,787.

[11] Planned Parenthood Federation of America, Inc. v. Schweiker, 559 F. Supp. 658 (D.D.C.), aff'd, 712 F.2d 650 (D.C. Cir. 1983). See also New York v. Schweiker, No. 83-0726 (S.D.N.Y. Mar. 14, 1983), aff'd, 719 F.2d 1191 (2d Cir. 1983).

The United States District Court for the District of Columbia also reviewed affidavits submitted by NFPRHA and others in the litigation challenging the regulations, and concluded that they "convincingly demonstrate that . . . [a parental notification requirement] will deter minors from attending family planning clinics and thereby increase their risk of becoming pregnant."[13] Citing what it described as "[t]he most carefully conducted and empirical study examining the question of whether adolescents would be deterred by a parental notification requirement," the court reported that "23% of those currently utilizing family planning clinic services would no longer do so if a mandatory parental notification requirement was imposed."[14] The court was "convinced" that minors would avoid clinics if a parental notification requirement was put into effect. The court relied on the affidavits submitted by "[s]everal experienced health care professionals," which estimated that, "if a clinic were to implement . . . [a parental notification requirement], two out of five minor patients would not return to the clinic. . . . In fact, anecdotal evidence indicates that the mere *proposal* of the notification requirement has resulted in a significant drop in adolescent attendance at family planning clinics."[15] Significantly, the court also found that "many minors will not quickly manifest the self-discipline counseled by the government and will remain sexually active. It is quite clear that, as the result of . . . [a parental notification requirement] substantial numbers of adolescents will become pregnant and will either elect abortion, or suffer the consequences of unwanted pregnancies."[16] In concluding that irreparable harm would occur if enforcement of the regulations was not enjoined, the district court stated: "It is abundantly clear to this court that many teenagers will be deterred from attending these clinics as a result of the parental notification requirement, and that the trust and client support established by the clinics over the past decade may be irretrievably lost."[17]

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[12] *See* *Planned Parenthood v. Heckler*, 712 F.2d at 658; *Planned Parenthood v. Schweiker*, 559 F. Supp. at 669.

[13] *Planned Parenthood v. Schweiker*, 559 F. Supp. at 663.

[14] *Id.* at 663 n.11, quoting Torres, Forrest and Eisman, *Telling Parents: Clinic Policies and Adolescents' Use of Family Planning and Abortion Services*, 12 Fam. Plan. Persp. 284, 290-91 (1980).

The District Court for the District of Columbia, therefore, enjoined the Secretary of HHS from enforcing the regulations.[18] The injunction was upheld by the United States Court of Appeals for the District of Columbia Circuit,[19] and became final when the Administration decided not to seek review by the Supreme Court. Thus, under existing law, as clearly expressed by Congress over the last fourteen years and now construed by the courts, clinics receiving Title X funds are to further Congress' paramount goal of stemming the epidemic of teenage pregnancies and are *not* to notify parents over a request for confidentiality by the adolescent.

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[15] *Id.* at 666 n.13, citing Kenney, Forrest and Torres, *Storm Over Washington: The Parental Notification Proposal*, 14 Fam. Plan. Persp. 185, 189 (1982) (emphasis in original).

[16] *Id.* at 666.

[17] *Id.*

2. *The Constitutional Limitations*

Congress normally has the power, of course, to change the law. Here, however, it is doubtful that the United States Constitution would permit Congress to require parental notice, at least in the case of minors denominated by the courts as "mature," regardless of their chronological age.

The Constitution guarantees women, including adolescents, the right to obtain contraceptives.[20] Indeed, the right of minors to have access to contraceptives flows a fortiori from their right to an abortion.[31]

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[18] *Planned Parenthood v. Schweiker*, *supra*.

[19] *Planned Parenthood v. Heckler*, 712 F.2d 650 (D.C. Cir. 1983).

[20] *See Carey v. Population Services International*, 431 U.S. 678 (1977) (plurality opinion); *Eisenstadt v. Baird*, 405 U.S. 438 (1972); *Griswold v. Connecticut*, 381 U.S. 479 (1965).

Moreover, it is clear that any law requiring a private physician to notify a mature minor's parents that she sought contraceptive services would be unconstitutional.[32] In H.L. v. Matheson,[33] the Supreme Court upheld a statute conditioning an abortion, for a minor stipulated to be immature, on parental notification. However, the majority opinion limited the holding to minors with "no claim . . . to . . . maturity."[34] Moreover, the three dissenters and the two members of the majority who joined in a concurring opinion by Justice Powell, stated that they would hold invalid a statute conditioning a mature minor's right to an abortion on parental notification.[35]

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[31] See Carey, 431 U.S. at 694 (plurality opinion).

[32] Almost every state in the Union has enacted a statute treating doctor-patient communications as confidential and protecting them with a privilege (see infra at note 38); and private doctors throughout the country overwhelmingly honor this privilege with respect to minors as well as adults. Thus, where a mature, albeit unemancipated, minor seeks her constitutional right to contraceptive services in the office of her private physician, the physician will not advise her parents in almost all cases. See infra at 24-25.

[33] 450 U.S. 398 (1981).

[34] Id. at 407. The Supreme Court had, a short time before, struck down an abortion statute requiring parental consent for failure to distinguish between mature and immature minors. Bellotti v. Baird, 443 U.S. 622, 643-44 (1979) (plurality opinion) ("Bellotti II").

[35] See 450 U.S. at 414, 418 (Powell, J., concurring) and id. at 475 (Marshall, J., dissenting).

The Eighth Circuit decided this issue in *Planned Parenthood Association of Kansas City v. Ashcroft*,[86] when it held unconstitutional a parental notification requirement because it required mature or "best interests" minors to give notice to their parents prior to the constitutionally-required court hearing provided by statute to afford such minors the opportunity to obtain an abortion without parental consent. Relying on the Supreme Court's analysis in *H.L. v. Matheson* and Justice Powell's opinion in *Bellotti II*, the Eighth Circuit found there are "persuasive reasons for concluding that parental notice is unduly burdensome in cases involving mature or 'best interests' minors."[87] And, just two months ago, the United States District Court for the District of Utah carefully analyzed the Supreme Court's rulings on parental notification and consent for abortion and contraceptives, and held that "the state may not impose a *blanket* parental notification requirement on minors seeking to exercise their constitutionally protected right to decide whether to bear or to beget a child by using contraceptives."[88]

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[86] 655 F.2d 848, 859 (8th Cir. 1981), *aff'd in part, rev'd on other grounds, vacated in part*, 51 U.S.L.W. 4783 (U.S. June 15, 1983). Because the State did not seek review of the Eighth Circuit's ruling on the parental notice provision, the Supreme Court did not address this issue. 51 U.S.L.W. at 4787 n.17.

[87] 655 F.2d at 859.

[88] *Planned Parenthood Ass'n of Utah v. Matheson*, No. C-83-0607W, Slip op. at 20 (D. Utah Dec. 30, 1983) (emphasis added).

A parental notice requirement applicable only to federally funded contraceptive services would appear to be equally unconstitutional. Congress may, of course, decline to fund contraceptive services altogether,[38] but there are cases suggesting that it may not fund them and then attach an unconstitutional condition upon their receipt.[39] If parental notice is a condition that may not constitutionally be imposed before a mature adolescent receives contraceptive services from a private physician, in a dual system of health care, where such a notice requirement is only imposed upon a mature minor's access to services from a federally funded clinic, the parental notice condition would appear equally unreasonable and equally unconstitutional.

It is undisputed that parents have an interest in preserving the family unit and in inculcating certain values in their children. These interests do not, however, rise to the level of a constitutional right; nor, according to the cases cited above, can they be legislated by the state as to mature minors. The Supreme Court cases I have already cited establish, without question, a mature minor's constitutional right to make decisions regarding abortion and contraceptives free from state-imposed requirements of parental notice or consent. Although the Court has recognized certain parental interests in these matters, it has consistently thwarted any legislative attempts by the states to intervene on behalf of parents and in opposition to the established rights of minors.[31]

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[38] Cf. Harris v. McRae, 448 U.S. 297 (1980) (holding no right to a federally funded abortion).

[39] Perry v. Sindermann, 408 U.S. 593 (1972); Sherbert v. Verner, 374 U.S. 398, 405 (1963); Speiser v. Randall, 357 U.S. 513, 518 (1958) (conditions upon public benefits cannot be sustained if they so operate, whatever their purpose, as to inhibit or deter the exercise of constitutionally protected freedoms). See also Shapiro v. Thompson, 394 U.S. 618, 631 (1969).

As the Fifth Circuit stated in determining that the parental consent requirement in a Florida abortion statute was unconstitutional: "We agree, of course, that parental control (that is, the continuing ability of the parent to direct the maturing minor's decision) is important to the stability of society, but we do not believe that this justification satisfies the constitutional standard" established in *Roe v. Wade*, 410 U.S. 113 (1973).[32]

Examining this same question, the district court in *Baird v. Bellotti*[33] recognized, "parents have years in which to teach their children, counsel them, and guide them. We may wonder how much would be accomplished by compulsorily affording a parent an eleventh hour opportunity, if adequate communication had not been established before. And we may wonder, also, whether imposing such burden on the minor would necessily [sic] improve the family relationship." As the Supreme Court noted in its recent decision in Akron v. Akron Center for Reproductive Health, Inc.,[34] "[a] majority of the Court . . . has indicated that these state and parental interests [on which parental notice and consent laws have been based] must give way to the constitutional right of a mature minor or of an immature minor whose best interests are contrary to parental involvement."

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[31] *See*, *e.g.*, *Bellotti v. Baird*, 443 U.S. 622 (1979) (plurality opinion); *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 74 (1976).

[32] *Poe v. Gerstein*, 517 F.2d 787, 793 (5th Cir. 1975) (footnotes omitted).

[33] 393 F. Supp. 847, 856 (D. Mass. 1975).

These parental interests are in any event not, strictly speaking, constitutional, in nature. The Constitution is not designed to protect parents from disobedient children. The Constitution is designed to protect the family from the State. Thus, the Subcommittee should be aware that the cases often cited in support of parental rights and control over children have uniformly concerned situations where the parents' claimed rights are compatible with the minor's, and not adverse. These cases involved laws which intruded on the right of the whole family to be let alone in certain private matters, by "unreasonably interfer[ing] with the liberty of parents and guardians to direct the upbringing and education of children under their control."[35]

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[34] 51 U.S.L.W. 4767, 4770 n.10 (U.S. June 15, 1983) (emphasis added).

[35] Pierce v. Society of Sisters, 268 U.S. 510, 534-35 (1925) (struck down Oregon statute interfering with children's attendance at private and parochial schools).

The factual situations in these cases involved an attempt by the State to *prevent* the parent and the child from making their own decisions.[36] Thus, the teaching of these cases is not that the State can legislate for or against parents; but, rather, that there are certain areas where the state is not allowed to intrude at all.[37]

3. The Policy Issues

Implicit in the law governing parental notice and consent are certain policy decisions that Congress, the courts and the states have expressed concerning the appropriateness of imposing a parental notice or consent requirement upon a teenager's access to family planning services. Thus, in the course of representing NFPRHA over the last year, I have been exposed to information and opinions which I believe should lead Congress to the conclusion that the law should remain as it is today on the issue of parental notice.

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[36] *See*, *e.g.*, *Wisconsin v. Yoder*, 406 U.S. 205 (1972) (compulsory secondary education law unconstitutional as applied to the Amish people as a violation of their free exercise of religion); *Prince v. Massachusetts*, 321 U.S. 158 (1954) (sustained conviction of guardian for violating Massachusetts Child Labor Law under claim that she was exercising her religious freedom as a Jehovah's Witness); and *Meyer v. Nebraska*, 262 U.S. 390 (1923) (struck down Nebraska statute forbidding children to study German and other foreign languages).

[37] In *Wisconsin v. Yoder*, the Supreme Court expressly limited its holding to a resolution of the asserted state and parental interests in the education of children, and stated that it "in no way determines the proper resolution of possible competing interests of parents, children, and the State . . ." 406 U.S. at 231.

First, the governments of forty states commented on the Administration's proposal to require parental notice. All forty opposed the regulations. Drawing on their practical knowledge and expertise in those states, the governments spoke strongly. The states warned that a parental notification requirement would discourage adolescents from obtaining needed contraceptive protection without affecting their sexual activity, and with inevitable increases in unintended teenage pregnancies, births and abortions. They took the Department of Health and Human Services to task for grossly overstating the risks of adolescent contraceptive use, and ignoring the far greater hazards of teenage pregnancy, abortion and childbirth. They asserted that the regulations would increase family discord and interfere with meaningful communication between many minors and their parents. They warned that the regulations would impose substantial administrative costs on family planning programs, many of which are state operated, and place an increased burden on society to subsidize additional abortions or support often indigent adolescent mothers and their children.

The comments of the State of Tennessee were typical:

> We join you in your concern for the health and well-being of the nation's adolescents . . . .
>
> We are no doubt in further agreement that teen sexual activity and the attendant high rate of high-risk pregnancies are inappropriate, undesirable, even tragic . . . .

> There is, however, convincing evidence that the proposed regulations would contribute to the undoing of exactly what they propose to accomplish, i.e., presumably, some reduction in adolescent sexual activity and pregnancy and an increase in parent-child communication.
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> . . . .
>
> Tennessee provides service each year to approximately 16,000 adolescents under the age of seventeen. A recent survey (February, 1982) conducted in Tennessee family planning clinics indicated that 46% of the adolescent population to be affected by this rule would not return to [the] clinic but would continue sexual activity . . . . In the event that even half of the 46% should become pregnant and seek state support through AFDC and Medicaid, using a conservative estimate of $3,000 per year as the cost of each pregnancy to the state, the total for the first year would be [$]11,000,000 . . . .
>
> . . . .
>
> . . . Long years of experience lead us to believe that parent-child communitation cannot be legislated nor forcibly regulated. This proposed mandate can only further polarize an already difficult situation.

Florida commented:

> We estimate that 10,000 girls in Florida will be negatively affected by the proposed rules. Of these we expect that 1,000 will become pregnant during the year and 500 will become new clients dependent upon governmental support. The cost to government for support of these new 600 clients will be over $1,220,000 for the first year of pregnancy and over $2,600,000 for the second year. This cost can be averted through making family planning medical and counseling services available to teens.

And South Carolina commented:

> The regulations do not address the very real and complex problem we face in our communities regarding teenage sexuality and pregnancy. In a national study it was estimated that if such requirements were in place, 36% of the teenagers now coming for family planning services would drop out. In South Carolina that would put approximately 4,000 girls at greater risk of pregnancy. Even if only a fraction of that number actually experience a pregnancy, it is far too high a risk. Thirty percent of pregnancies to girls seventeen and younger in South Carolina result in induced abortion. It is clear that these regulations will result in increased births and abortions to teens.

Governor George Busbee of Georgia stated the matter clearly:

> Our position is a realistic one--witholding [sic] such [contraceptive] information and devices does not diminish the sexual activity of teenagers. It only makes them more vulnerable because of such activity.

Mississippi's State Health Officer made this comment:

> I support the overall goal of these proposed rules which is to encourage parental involvement in the decision making and actions of unemancipated minors dealing with their sexual activity and the results therefrom. I must strongly object, however, to several provisions of the proposed rules as they will, in my opinion, contribute little that is constructive to the overriding goal but will impede and frustrate our efforts to prevent unwanted pregnancies and the many damaging effects of such pregnancies on the young person involved, on the family, on the community and on society at large.

And Texas warned:

> As a state with one of the highest teenage pregnancy rates, Texas cannot afford to limit teenagers' access to family planning services. We have no doubt that, were these regulations to become final, they would adversely affect the rate of teenage pregnancies, abortions and out-of-wedlock births.

Second, virtually every major medical association in the country commented on the proposed parental notification regulations and all were opposed. No fewer than 19 medical organizations, including the American Medical Association, the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American College of Physicians, the American Society for Internal Medicine, and the Society for Adolescent Medicine, opposed the mandatory parental notification regulations when first proposed by the Department of Health and Human Services in 1982. The remarks of the American Academy of Pediatrics were typical of the views of all these groups. The Academy noted:

> The facts are clear. Teenagers will not assume measured responsibility for their sexual behavior if parental knowledge of their activity is mandated. Instead, they will risk pregnancy and all the attendant social, emotional and medical hazards. The increased pregnancy rate among adolescents that inevitably would ensue means one can expcct a greater number of lives [sic] births, forced and often unstable early marriages and stepped-up demand for abortion . . . .

Third, these concerns were not limited to medical groups. In fact, most people who deal directly or indirectly with the problem of unintended adolescent pregnancies say the same thing. When the parental notification regulations were first announced, they drew opposition from scores of organizations ranging from the United States Conference of City Health Officers and the Salvation Army to the Girls Clubs of America.

Fourth, the private medical community -- doctors serving most of the country without support of federal funds -- has, since the beginning of the profession, served patients -- including minors seeking contraceptive services -- on a confidential basis. The concept of medical confidentiality originated well over 2,000 years ago. As early as 450 B.C., Hippocrates declared:

> What I may see or hear in the course of treatment in regard to the life of man which on no account must spread abroad, I will keep to myself, holding such a thing as shameful to be spoken about.

This standard survives virtually unchanged in the American Medical Association's fourth principle of medical ethics:

> A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.

Many people find the details of their medical treatment intensely personal and potentially embarrassing, and have an understandable desire to keep those details private. Moreover, a number of people would not seek medical treatment at all if they were not assured of confidentiality, and it could hardly benefit society if people were discouraged from seeking needed treatment. With these considerations in mind, most states have adopted statutes protecting physician-patient confidentiality, in general,[30] as well as statutes that expressly authorize minors to consent to family planning treatment[**] and treatment for venereal disease, pregnancy, alcohol and drug abuse and mental health problems. Few would dispute the value of such protections.

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[30] A majority of states have enacted statutes limiting a physician's duty to testify. *See, e.g.*, Ariz. Rev. Stat. Ann. § 12-2235 (1982); Ark. Stat. Ann. § 28-1001 (Rule 503) (1979); Cal. Evid. Code §§ 990 *et seq.* (Deering 1966 & 1982); Colo. Rev. Stat. § 13-90-107 (1973 & 1981); D.C. Code Ann. § 14-307 (1981); Ga. Code Ann. §§ 24-9-40 *et seq.* (1982 & 1982 Supp.); Idaho Code § 9-203 (1982); Ill. Ann. Stat. ch. 51 § 5.1 (Smith-Hurd 1982-1983); Ind. Code Ann. § 34-1-14-5 (Burns 1982); Iowa Code Ann. § 622.10 (West 1982-1983); Kan. Stat. Ann. § 60-427 (1976); Ky. Rev. Stat. § 213.200 (1977); La. Rev. Stat. Ann. § 3734 (West 1982); Mich. Stat. Ann. § 27A.2157 (Callaghan 1976); Minn. Stat. § 595.02 (1976); Miss. Code Ann. § 13-1-21 (1982); Mo. Ann. Stat. § 491.060 (West 1983); Mont. Code Ann. § 26-1-805 (1981); Neb. Rev. Stat. § 27-504 (1979); Nev. Rev. Stat. § 49.225 (1981); N.H. Rev. Stat. Ann. § 329.26 (1981); N.J. Stat. Ann. § 2A:84A-22.2 (West 1976); N.Y. Civ. Prac. L.R. § 4504 (McKinney 1981-1982); N.C. Gen. Stat. § 8-53 (1981); N.D. Cent. Code N.D.R. Evid. 501, 503 (1981); Ohio Rev. Code Ann. § 2317.02 (Page 1981); Okla. Stat. Ann. tit. 12, § 2503 (West 1982-1983); Pa. Stat. Ann. tit. 42, § 5929 (Purdon 1982); S.D. Codified Laws Ann. §§ 19-13-6 *et seq.* (Rule 503) (1979); Utah Code Ann. § 78-24-8 (1977); Vt. Stat. Ann. tit. 12, § 1612 (1982); Va. Code § 8.01-399 (1977); Wash. Rev. Code Ann. § 5.60.060 (1982); Wis. Stat. Ann. § 905.04 (West 1982-1983); Wyo. Stat. § 1-12-101 (1977). Medical ethics and state laws and decisions in the other states further protect a patient from disclosures by his physician in circumstances other than compulsory testimony. *See* Ariz. Rev. Stat. Ann. § 32-1401 (1976 & Supp. 1981-82); Ark. Stat. Ann. § 72-613(O) (1979); Cal. Bus. & Pro. Code § 2263

In a nationwide survey of 932 doctors from the American Academy of Pediatrics and the Society for Adolescent Medicine,

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[Footnote continued]

(Deering 1970 & Supp. 1982); Del. Code Ann. tit. 24, § 1731(b)(12) (1981); Idaho Code § 54-1814(13) (1979 & Supp. 1982); Kan. Stat. Ann. § 65-2837(b)(6) (Supp. 1979); Ky. Rev. Stat. § 311.595(15) (1981); Me. Rev. Stat. Ann. tit. 32, § 3282(5)(D) (1978 & Supp. 1982-83); Neb. Rev. Stat. § 71-148 (1979); N.M. Stat. Ann. § 61-6-14(B)(5) (1978); N.D. Cent. Code § 43-17-31 (1978 & Supp. 1981); Ohio Rev. Code Ann. § 4731.22(A)(4) (Page Supp. 1981); Okla. Stat. Ann. tit. 59, § 509(4) (1980 & 1981-1982 Supp.); Or. Rev. Stat. § 677.190(6) (1981); S.D. Codified Laws Ann. § 36-4-30(4) (1979 & Supp. 1982); Tenn. Code Ann. § 63-6-214(a)(7) (1982).

[**] Alaska Stat. § 09.65.100(4) (1981 Supp.); Cal. Civ. Code § 34.5 (1982 Supp.); Col. Rev. Stat. § 12-22-105 (1973); Del. Code Ann. tit. 13, § 708 (1981); Fla. Stat. Ann. § 381.382(5) (1973); Ga. Code Ann. § 88-2904(f) (1979); Hawaii Rev. Stat. § 577A-2 (1981 Supp.); Ill. Stat. Ann., ch. 111 1/2, ¶ 4651(5)(6) (1982); Iowa Code Ann. § 234.21 (1981 Supp.); Kan. Stat. Ann. § 23-501 (1979 Supp.); Ky. Rev. Stat. § 214.185 (1977); Me. Rev. Stat. Ann. tit. 22, § 1903 (1980); Md. Laws, Advance Sheets, Part 2, ch. 22, § 20-102(5) (1982); Miss. Code Ann. § 41-42-7 (1981); Mont. Code Ann. § 41-1-402 (1981); N.M. Stat. Ann. § 24-8-3 (1978); N.C. Gen. Stat. § 90-21.5(a) (1981); Okla. Stat. Ann. tit. 63, § 2602(3) (1981 Supp.); Or. Rev. Stat. § 109.640 (1977); S.C. Stat. at Large, Sec. 20-7-280 (1981); Tenn. Code Ann. § 53-4607 (1977); Va. Code § 54-325.2(D)(2) (1982).

Other states have codified the "mature minor" rule, allowing such minors to consent to medical treatment. See Ark. Stat. Ann. § 82-363 (1981 Supp.); La. Rev. Stat., tit. 40:1095 (1977); Miss. Code Ann. § 41-41-3(h) (1972); Nev. Rev. Stat. § 129.030(2) (1979).

94 percent of the doctors said they would honor a request by a 17-year-old patient that her parents not be informed of her contraceptive treatment and 79 percent said they would honor such a request by a 14-year-old. When the minor was stipulated to be mature in the doctor's judgment, the figures went up to 97 percent and 81 percent, respectively. It should be obvious that this practice would not be the norm unless doctors were confident that they could obtain the necessary medical history and provide safe and effective treatment without involving parents. On the contrary, it is evident that physicians primarily rely on information provided directly by minor patients and on their own tests and observations to determine appropriate treatment.

In sum, for the Congress now to require parental notice for publicly funded contraceptive care, it would have to: 1) reject the practice followed in the private medical community; 2) reject the strong policies of all forty states expressing themselves on the issue; 3) reject the views of all major medical groups and all major family planning groups in the country; 4) reject the previously expressed will of Congress throughout the successful history of Title X; 5) enact a statute that would probably be held unconstitutional; and 6) almost certainly doom society and, in particular, adolescents to thousands of additional abortions and unintended births.

In conclusion, I wish to point out that NFPRHA and these other groups and organizations are not insensitive to the significant interest parents and children have in parents' involvement in their minor childrens' decisions regarding sexual activity and contraceptive use, and the desirability of fostering such involvement. Family planners generally agree that parents should ideally be centrally involved in the sex education of their children; that in order to be involved effectively in sex education, many parents need to be better informed and should develop better communication skills; and that, when family planning providers offer family life and sexuality education programs, the programs are more effective when parents contribute to the planning process.

Currently, all family planning programs counsel their teenage patients to involve their parents in their family planning decision-making. This practice prevailed even before Title X was amended in 1981 explicity to require such encouragement. In addition to their counseling, federally-funded family planning clinics have established a wide array of programs designed to foster family involvement in their adolescents' family planning decisions. These programs include: the development of parental communication skills and the ability to provide sex education and counseling to their children; opportunities for parent/child communication and counseling; general community education programs for teenagers and parents; and parental participation on advisory boards.

It is through efforts such as these that Congress' directive to encourage family involvement will be achieved. Mandating parental notification or consent will not foster better parent/child communication where it does not otherwise exist. Rather, it may only tend to undermine the progress that family planners have achieved in counseling and providing essential services to adolescents while, at the same time, promoting family involvement.

I would like to thank the Chairman and Members of the Subcommittee for the opportunity to participate in this hearing. If you have any questions, I would be pleased to answer them.

Senator Denton. Mr. Rees?

Mr. Rees. Thank you, Mr. Chairman.

My name is Grover Rees. I am a law professor at the University of Texas Law School, where I teach constitutional law.

In the interest of saving time, I will not address the point raised by Mr. Nields about statutory interpretation. The question as I understand it today is whether Congress may, if it wishes, enact a law, and whether Congress should enact a law under which parental notification to parents of minors involved in adolescent sexuality programs and contraceptive programs would be provided.

Senator Denton. And that law, in that specific regulation, which I did not initiate the suggestion of, by the way, applied to minors who receive prescription drugs or devices for the purpose of contraception—prescriptions.

Mr. Rees. That is right.

Senator Denton. Prescription drugs or devices.

Mr. Rees. I think in the case of prescription drugs, the law perhaps even more clearly ought to require such notification, but I do not believe it necessary that they be prescription drugs in order for it to be a good idea, and not an unconstitutional idea, for Congress to require parental notification—except, perhaps, in extraordinary cases where the minor might be threatened with violence or some harm of that nature.

First, to address briefly Mr. Nields' argument that it is unconstitutional, there is a distinction, as I think you perceived, Senator, between court decisions that say that the Government may not prohibit something and court decisions that say that the Government must pay for something. And that is really the distinction here, between the Carey case, which says that the Government cannot prohibit teenagers from receiving contraceptives, and the question here, which is whether the Government should, when it is funding the distribution of contraceptives, distribute them to minors without parental notification.

Now, the unconstitutional condition rationale which is frequently advanced is in most cases, I believe, a circular rationale, because it assumes away the distinction between paying for something and not prohibiting it, or between prohibiting it and not paying for it.

This exact rationale, or one very similar to it, was advanced in *Harris* v. *McRae*, where the opponents of the Hyde amendment, which banned most Federal payments for abortions, said:

> Well, the Federal Government does not have to pay for any operations at all. It does not have to pay for abortion or childbirth. But if it pays for either, then it is the imposition of an unconstitutional condition to say that you must choose childbirth.

That was rejected by the court. I cannot exactly predict what the court would do, but I just want to make it clear that it does not follow as the night follows the day, from Carey, that this kind of law would be declared unconstitutional.

The mature minors' point is another one that I would like to address briefly. If Congress felt that it would be unconstitutional, that the courts would hold it unconstitutional, for a law requiring parental notification to be applied to mature minors receiving Government-funded contraceptives, a belief that I do not share, it seems to me that they could meet the requirements laid down in related court cases simply by providing that a minor who believes that she is mature can go to a judge and get an exemption from what would be the normal course of the law, which would be parental notification. If you want to provide for parental notification, but you do not want it to apply to minors whom the courts would deem mature, then I believe you could meet that standard by simply providing that in an appropriate case, a minor who argues that the law should not apply to her, could go to a judge and prove that she is mature, and thus avoid the requirement of parental notification, which could still be provided as the general rule.

However, I want to argue not just that it is not unconstitutional to enact this law to provide for parental notification, but that there is a strong parental interest, which may rise to the level of a constitutional right, in having parental notification.

The U.S. Supreme Court has long recognized what the court in *Prince* v. *Massachusetts* called a private realm of family life which the State cannot enter. In *Prince*, the court stated:

> It is cardinal in the hierarchy of constitutional precepts that the custody, care, and nurture of the child reside first in the parents, whose primary function and freedom include preparation for obligations the state can neither supply nor hinder.

In *Wisconsin* v. *Yoder*, the constitutional rights of parents to direct the moral and religious training of their child, said the court, "is never more fundamental than at the child's crucial adolescent period of religious development."

In the case of *Pierce* v. *Society of Sisters*, the court found that compulsory public education laws were an unconstitutional assertion of what the court called a general power of the State to standardize its children, and that, in the words of the court:

> The child is not the mere creature of the State. Those who nurture him and direct his destiny have the right, coupled with the high duty, to recognize and prepare him for additional obligations.

Finally, in the recent case of *Moore* v. *The City of East Cleveland*, the court characterized the right that had been recognized in previous cases as:

> One that protects the sanctity of the family, precisely because the institution of the family is deeply rooted in the Nation's history and tradition. They said that the family is the institution through which we inculcate and pass down many of our most cherished values, moral and cultural.

Now, these cases involved primarily public education. Pierce involved the right of parents to keep children out of public schools. Yoder held that parents had the right to keep children from all conventional secondary education in order to prevent them from conflict, from exposure to worldly influences that conflicted with the parents' own values.

I believe that the Government interest in contraception is far less compelling than the Government interest in education, and therefore that it is a far less controversial assertion than those actually accepted by the Court in cases like Pierce and Yoder that parents have the right, not to veto contraceptive choices by their children, but simply to have notification, simply to be able to compete on fair terms with paid agents of the State who are otherwise interposing themselves between the child and the parent, and thereby interfering with the parents' right to inculcate moral and religious values in the child.

Senator **Denton**. The blunt way in which Secretary Schweiker expressed that was to slam his hand on the table over in the House and say, "You are trying to impose a Berlin Wall between the child and the parent."

Mr. **Rees**. Well, I think that is an apt metaphor in some ways, Senator.

Now, I am not maintaining—I am not trying to predict that the courts, even with proper plaintiffs, which we did not have in some of these other cases—would strike down a law that provided for adolescent contraceptives and did not provide for parental notification. No court has addressed that constitutional issue, but I do not predict that they will. I do not think that Yoder and Pierce compel the result that I am suggesting. However, I also do not think that Carey and Bilotti and the abortion cases compel the result that Mr. Nields is suggesting. I think this is one of those areas where Congress will be able to get away with doing whatever it wants to do, that the courts will not strike down a law requiring parental notification, and they will not strike down a law that does not permit parental notification, although I would argue that they should.

And if the Constitution, or if the Court's interpretations of the Constitution, do not say anything either way—which they clearly do not at this point—Congress has to make its own inquiry into what the Constitution says, and I think it is important that you look not only at the Court, but also at the framers of the Constitution, the people who ratified it. And when you frame the question that way, when you ask what the people who framed, for instance, the 14th amendment, would have thought they were protecting—were they protecting, on the one hand, the right to adolescent sexuality; were they protecting the right of adolescents to receive contraceptives without parental permission, or is it closer to the mark that they, and that the people who framed the original Federal

Constitution were trying to protect the right of parents to inculcate their children with their own values? I really think that the second right is closer to the historical Constitution and what it means than the right that is asserted by Mr. Nields.

Now, if I could comment briefly on the policy question, which is what is left if you decide that the Constitution does not dictate anything either way, it is the case that the family planning community, which is the group that Mr. Nields represents, feels strongly that the only thing that is going to happen, or the most important thing that is going to happen, if you require parental notification is that children or adolescents will stay away from the clinics but will still have sex.

Now, the question that Congress has to resolve, and the question that I think Congress can resolve without necessarily having to rely on experts who tend to be affiliated with the grantees themselves, is whether there will also be an offsetting effect, or whether there is currently an offsetting effect whereby these clinics which do not provide parental notification encourage the trend—which, certainly, other social factors are encouraging—toward adolescent promiscuity, toward premarital sex among 13- 14- and 15-year-olds.

I argue that it does. I will submit a written statement which elaborates this.

But the one point that I would like to make here is that the law has a teaching function. The very fact that there is an arrangement for confidentiality, and that this arrangement for confidentiality is endorsed by the Government, is bound to send a message to the teenagers about what their relationship with their parents ought to be—not only about whether adolescent sex is such a bad thing, but also about whether it is a good idea for their parents to be involved in the decision. Even when Government does not prohibit something, even when it does not require something, it inevitably affects human behavior. And for a paid agent of the State or the Federal Government to be keeping sexual secrets with an adolescent, secrets from the parent, I believe, presents constitutional problems. In any case, it ought to present profound policy problems.

Thank you.

Senator DENTON. Thank you, Mr. Rees.

We have merged today a number of related issues in this field. We have the overall question of what exists now in the field and is funded at something approaching $200 million when you consider private and public funds.

From my own—I hope—objective belief, consider that that is at best value-free sex counseling, which contradicts the parents' right and obligation to be able to interpose their version of values to their own children. That is one issue.

We have the issue of the parental notification regulation which the Department of Health and Human Services imposed, and then you won, Mr. Nields, in getting a Federal judge to decree that that was incorrect, that the intent of Congress was not—I think this was your main point—sufficiently explicit on that point to permit it. Then you also threw in some other reasons for—that is, subjective reasons—such as that it would mean more pregnancy, more abortion, and so on. There is that issue, which I personally hope is not closed. The administration did not choose to appeal that; I regret that.

The third issue is that the adolescent and family life bill—which, for your information, is the only program the Federal Government has targeted exclusively at teenage pregnancy and parenthood—is my bill. It was interpreted by most of the media as being an effort on my part to impose some sort of morality. Quite the contrary. It was intended to correct an already-imposed immorality, which the government was paying for, and transmitting secretly, through family planning grantees, to our children, and I wanted to provide an alternative approach. I agree that in my own heart, I did not expect at that time that such a notification would come from HHS. I thought the battle, if you will, on that, or the debate or the discourse on that would proceed at a slightly slower rate.

This program now, however, the Adolescent Family Life Act—and let me review it very briefly, so we know what we are talking about—funds local public and private nonprofit organizations that offer a wide variety of services, including family planning services, to adolescents. With a few exceptions, grantees are required to notify and obtain the permission of parents or guardians before providing services to unemancipated minors. It is voluntary for a kid to go to one of those clinics. It is under attack by ACLU, by employees of ACLU who are masked as just taxpayers, and by members of Planned Parenthood, who are presented in other roles. So it is a battleground, and there will be a ruling on that.

The exceptions to the requirement for the permission of parents or guardians before providing services for unemancipated minors are as follows: first, when the minor is requesting only a pregnancy test or venereal disease treatment, the parent is not notified; second, when the minor is a victim of parental incest; third, when an adult relative of the minor certifies that if the parents were notified, the minor would be physically abused; and fourth, when the parents of the minor are attempting to compel her to have an abortion.

In addition, if the minor is already pregnant, only parental notification, but not permission, is required.

Another requirement of grantees is that they neither perform abortions nor make referrals for abortion or abortion counseling, a fifth issue—which I hope we do not get into—except when the minor and her parents request, an abortion counseling referral may be made.

That one is now under attack, too.

I hope that the two sides of this tend to avoid the sense of gamesmanship which tempts both sides, I am sure, to become nonobjective. I hope we work toward that commonality, which the previous panel of witnesses seemed to agree is potentially there. And I hope we can resolve the respective questions which you two gentlemen have been discussing—for example, if Congress needs to further delineate what its intent is—which I believe is desirable, although I am not sure required, in order for, in the argument of Mr. Rees, to permit the regulation to have stood were it to be appealed. I would like to see it appealed.

But again, I am not seeing myself as omniscient in this. I just feel it is pretty difficult for anyone, any human being, to decide when a parent loses his or her right to—this is within the argument—to say to a girl or a boy, "You are not going to sleep with Mary or John."

Now, that is a question we have not addressed, but does that end at 11, or 12 or 13? It probably ends somewhere, because even in the most moralistic beliefs, one has to concede that an individual has the right to exercise his or her free will. At what time in life does that transcend the parental right, or the Commandment, "Honor they father and they mother," and listen to what they say?

I do not know. I do not know.

Mr. REES. Senator, I am 32, and my mother has not given up that right yet.

Senator DENTON. Nor mine. And until my father died, although I was not supported by him after the seventh grade, I obeyed him. I honored him; I loved him. And I think that that right is important here, and one which we really have not considered that carefully. We have not even gotten into the consequences of the act of a commitment to habitual premarital sexual intercourse, which the parent is held liable for the consequences of—which makes it not only a right, but a just decision that he or she has participation in the decision made by the child. So it is a complex question, and as I say, I do not pretend omniscience. But I think something is off-balance right now that needs to be brought back toward somewhere else.

Mr. NIELDS. May I address that, Mr. Chairman?

Senator DENTON. Yes.

Mr. NIELDS. I think it is a very important question, and I think it raises other important questions. Speaking, I think, for NFPRHA and certainly for myself, the family, I believe—we believe—is perhaps the most important institution in our society, but it is the family that is the important institution. It is a very private, but very important thing. And the question of when a child becomes old enough so that it makes its own decisions, so that it is not under the authority of the parent, is a question to be decided within the family. It is a question—and parents would do well to do more about bringing up their children—but that is a question to be resolved within the family——

Senator DENTON. It is usurped from the family's decision if the Government intervenes before that question is even raised and starts exclusively, confidentially discussing a subject of great importance to the person in that family and to the possible person to be born to that person, if she is female. The Government usurps that very question. It begs that question. That is what I think Mr. Rees was getting at in regard to his circular argument point. The only thing I am good at is logic. I did not have to take the course because I answered the question this guy had given for 40 years on the first day of the class. He could not believe that when he had asked half the question, I knew the rest of it and the answer—it was the only gift God gave me.

But I see the same thing that Mr. Rees he sees respecting this. I believe that there are legal arguments that can be made very persuasive, and never have I regretted more that I am not a lawyer than now, because I would love to defend this issue, perhaps under slightly different circumstances. Maybe we could write a better law. We did our best on the adolescent family life bill. It was agreed to by Representative Waxman, and when we started talking about what congressional intent was for title X, we were getting down to conversations that were held between him and me, in private, in good will, in which there was some discrepancy as to the meaning that each person had in putting down these words. It was not a big congressional discussion, I assure you. And I respect the man as being sincere. I just hope that we can get more familial involvement than we now have.

I hope that we can as a nation, as a government, reflect—although it might not reflect the views of everyone here—they did say things like "endowed by their creator with certain inalienable rights." Now, that is either baloney, or it is not. But it was the revolutionary part of our revolution, because up to then it was a king, and we said, "No. It is God who endows the rights." And then we talked about the specific rights, which were self-evidently endowed: Life, liberty, and the pursuit of happiness. All three are involved in this general subject area—abortion, for one—is it life? Oh, yes. Is it a citizen? Who knows. But it is life. And the pursuit of happiness has to be conducted by the understanding of our Founding Fathers in the consideration of the Judeo-Christian ethic, the underlying statutes of which were the Ten Commandments. Those in our society, who are growing in number, who think that is a lot of baloney, cannot necessarily rewrite that Constitution, nor the last words, about, "with the utmost reliance upon divine providence," et cetera. You know, that is part of it, too.

Mr. REES. Senator, if I could comment on part of the general thrust of your remarks, I certainly agree with you and with Mr. Nields that it is well and good to find and sometimes to emphasize common ground, and part of the common ground is that we all believe the family is important. However, it is also important in cases like this to underline the differences, so we will know what we cannot agree on and have to argue about.

And, as you pointed out, the question is, whether it follows from the importance of the family that the government will not intrude into that relationship between the parents and the child, except with extremely compelling cause. Except in cases, for instance, where the parents have shown that they will abuse the relationship. And I think that is really what the parental notification question is about.

Senator DENTON. Well, that was my understanding, but it was overthrown by a Federal judge. There are a lot of people out there in the country who feel that Federal judges are changing the Constitution by legislating. Certainly, my State is one.

Mr. REES. Well, Senator, I certainly would agree with you on that generally, but this case was a statutory interpretation case. It did not reach the constitutional arguments. It did not reach the arguments that were made by Planned Parenthood and NFPRHA that it was unconstitutional to require parental notification, and it did not reach our arguments, because our our defendants were not allowed to intervene. It did not reach our argument that there was a parental right to notification. The courts have not decided that question, and as long as they have not decided that question, you are free to legislate at least until they do decide that question. You are free to legislate in accordance with your own view of what the Constitution says and of what sound policy is.

And I would not—if I could leave you with one message about this—do not be intimidated by the ACLU asserting special knowledge about what the Constitution means. The ACLU has a lot of fine people in it, but they have got, in my view, some funny ideas about individual rights and about what the Constitution provides. The only parental right that I know that they recognize is the right to take your child back to the Soviet Union when he does not want to go. They were on the parents' side in that case, in the *Walter Polovchak* case, and they felt that parental rights were very important. But in cases involving contraception and abortion, they believe that it is the right of the child that is more important than the right of the adult.

Now, they are entitled to their opinion, but we are entitled to our opinion, too, that the Constitution does not protect your right to take your child back to the Soviet Union—because it is a worse thing to be taken back to the Soviet Union than to be denied contraception or abortion—and that it also does not protect the right of an adolescent to be free of parental involvement in sexual decisions.

Senator DENTON. Well, you may be pioneering in this field, in which both liberals and conservatives, who are not necessarily divided along the lines of this argument, agree is sort of a national crisis in that we do have a dissolution of the family; we do have, if not an accomplished sexual revolution, which a nation should accept, at least, the beginnings of one, with endemic consequences in many ways.

So, as we proceed, and as I proceed—you do not see a lot of Senators here—the level of understanding of this issue on the floor is about 2 percent of what it is in the mind of any one person out there; I can tell you that right now, and that is a very sad and frustrating fact to me—but as we continue to try to pioneer in this field, that is, to correct what all of us agree is a vital problem, I not only solicit your advice, Mr. Rees, but also yours, Mr. Nields, and would grant you the last word in this.

What would you have to say?

Mr. NIELDS. Thank you, Mr. Chairman.

I did want to respond to this notion that there is some kind of constitutional right in the parent to continued control over the child. I think I agree with what Mr. Rees said in his first remarks, which is that he did not think that a court would ever make that holding, and I think he is correct. I know the cases he is talking about that talk about the sanctity of the family, and I agree with them, and I take note of them, but I believe they establish the opposite of what he is arguing for.

Our Constitution does not address the relationship of two private individuals. It does not address the relationship of parent to child. Our Constitution is a fundamental document, and I agree with the chairman that is was an act of genius. It regulates the relationship between Government and individuals. It puts a limitation on the kinds of things that the Government can do coercively to the individual.

There are cases which say—and I will quote it again—that the Constitution recognizes "a private realm of family life which the State cannot enter." It protects the whole family from intrusion, coercive intrusion by the State. In totalitarian societies, the State can tell families what to do. They can tell them when to have children, they can tell them what to talk about and what not to talk about in their home. In our society, the Federal Government cannot tell us what to talk about in our home. I believe that a fundamental proposition of our way of life and our system of government is that parents and children work out their own relationships inside the family, and that the Federal Government should not tell parents and children what they should talk about and should not weigh in on the side of either part in that very private relationship.

Thank you, Mr. Chairman.

Senator **Denton**. I would feel, I must say, Mr. Nields, that it is an intrusion, certainly from the point of my family, and frankly, every family that I know of, for the Federal Government to give value-free, or even sexually promotive advice and counsel and movies and telling them to fantasize if they are not getting—what do they call it—I will just use the term, "with it," but "If you do not feel 'with it,' fantasize. The best source of that is in your brain." That is in this film. And, if you do not like it heterosexually, try it homosexually; that is OK, no matter what your parents say. It has two advantages, the literature says: No pregnancy and no venereal disease. That came out before AIDS, but it is still being shown. I consider that an intrusion, and that is why I introduced my legislation.

So I agree with you about the intrusion. I am just asking who is intruding and who is correcting an intrusion.

Mr. **Nields**. I appreciate that, Mr. Chairman, and I respect it, but I would like to make two points in response. One is that, as a matter of constitutional law, I do not know of any case that has ever said that the Federal Government violates the rights of individuals by funding a benefit.

My second point——

Senator **Denton**. Sex counseling without the family's contribution to the value part of it, I do not consider a benefit—all other things notwithstanding.

Mr. **Nields**. I do not either, and if that is happening, it is not——

Senator **Denton**. I wish you would come and see the movie and the literature.

Mr. **Nields** [continuing]. Not part of the policy of my client. NFPRHA represents local health officers. We had the State of South Carolina as a party in our lawsuit——

Senator **Denton**. Well, you are invited to come to my office and look at the film, and if you want to tell me that this thing is not, at best, value-free, and at worst, pushing them toward it, I will be happy to hear your opinion. And that is Planned Parenthood, whom you also represent.

Mr. **Nields**. Based on what the chairman has said, I do not need to. I would not disagree with it.

I would like to address one final question, which is that the private sector, private doctors, based on studies which are in my testimony, themselves will treat adolescents and will prescribe contraceptives without notifying parents.

Now, that means people who have enough money to pay for it can go to private doctors and can get contraceptives without their parents being notified.

Now, that may be good or it may be bad, but it is what is happening. I do not view it as a violation of constitutional rights or an intrusion. And what the Federal Government is doing, as I understand it under title X, is funding for those who cannot pay for it—the same thing for poor people that the private sector is making available for people who can pay for it.

Senator **Denton**. Well, that's leaving out the sex counseling part of the equation.

Well, thank you very much, gentlemen.

Mr. **Rees**. Senator, could I make one correction, because Mr. Nields did characterize my position in a way that I do not think is accurate.

I do not think I said, and certainly do not mean to say, that no court would ever hold that there is a parental right to be free from the kind of Government intrusion that is represented by distribution of contraception without parental notification.

I said I was not predicting that. I was not predicting anything about what courts would say one way or the other. I do think that the Constitution provides such a right. But I am often disappointed in what the courts think the Constitution says.

[The following was received for the record:]

The Joseph P. Kennedy, Jr. Foundation

1701 K STREET, NORTHWEST, SUITE 205
WASHINGTON, D. C. 20006
(202) 331-1731

[illegible] MAR 14 AM 9 30

March 8, 1984

The Honorable Jeremiah Denton
516 Senate Hart Office Building
Washington, D.C. 20510

Dear Senator Denton:

Thank you for inviting me to participate in your subcommittee hearing on "Parental Involvement with their Adolescents in Crisis." I am sorry that my schedule would not permit me to attend, but I am following the important works of your subcommittee with great interest.

The resolution you propose to introduce speaks to an issue which I believe deserves the attention you are focusing upon it. Our nation has no policy which supports and sustains the family as the basic unit of our society and the source of our moral and spiritual strength.

On the issue of adolescent pregnancy, I have testified before the Senate that "instead of more money for birth control or value-free sex education, we need efforts to strengthen family commitment and marriage and get at the problems that lead adolescents into early sex activity."

To be sensitive to the fundamental needs of adolescents, all government supported programs must be concerned with two goals: nurturing of caring relationships among parents and their children; and supporting marriages that endure.

Unfortunately, most services to adolescents are provided with no regard at all to their impact on family stability and parental responsibility. Yes, minor children have rights. But, parents have rights, too, and these rights include the right at least to know when their children are embarking on any course that is hazardous to their health and well-being, the right to know when family secrets are being encourage that can destroy family communication and trust. At the very least, our nation's laws and regulations should give parents the chance to communicate with and support their children in situations when they have sought treatment, care or counseling for crisis conditions about which the parents may be completely in the dark.

Your resolution, I believe, with its exceptions and safeguards, would reinforce the rights of parents to participate in the lives of their children without being intrusive; to help, not to harm; to support, not to punish; to unite, not to divide.

I applaud your own unshakable faith in the family and hope that through your moral leadership, our government can begin to put the strength of families at the head of its list of priorities.

Please let me know how I may help in this effort.

Sincerely,

Eunice K Shriver

Eunice Kennedy Shriver

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William A. Long, Jr., M.D.
F.A.A.P.
[illegible] LAKELAND DRIVE
JACKSON, MISSISSIPPI [illegible]
TELEPHONE [illegible]

PRACTICE LIMITED
TO ADOLESCENTS

[illegible] FEB 23 PM 7:03

February 23, 1984

The Honorable Jeremiah Denton
United States Senator
United States Senate
Committee on Labor and Human Resources
Washington, D. C. 20510

Dear Senator Denton:

After a second telephone conversation with Mr. Karl Moor of your Washington Office Staff, I am now writing in response to your initial request that I provide written testimony concerning the subject matter of the Resolution you have drafted toward establishing the groundwork for a uniform National policy with regard to the care, treatment, and counseling of adolescents who are overcoming the problems of drug dependence, alcohol abuse, mental illness, early sexual intercourse, or unplanned pregnancy. I am enclosing a copy of my Curriculum Vitae in order that you gain better insight into my own background and training; perhaps this will allow you to more honestly interpret my comments and opinions!

My practice of the past fifteen years has been dedicated solely to the medical care and counseling of adolescents (limited to the 11-20 year age group), so I will comment largely from experience as well as from conviction, and I sincerely hope this will be of some practical benefit to your Subcommittee in its deliberations. I am personally a firm believer in maintaining the integrity of the patient's family as his firmest bulwark and ally, unless of course that family has obviously become adversarial to the young person as judged by the collective eyes of medical, legal, and social agency professionals. My own experience sees the family in general to be well-intentioned, although at times ill-advised, in their actions toward and on behalf of their youngsters. With the cooperation of caring professionals, that family will usually become a prime resource of recovery for the individual child, and in my opinion all effort should be expended to recruit the help, cooperation, support, and moral guidance of that family.

There are just a few delicate and controversial areas in such an effort in my experience, so please allow me to comment on them one by one.

(1) The physician (or other professional) faces the constant dilemma while dealing with an adolescent of maintaining trust. This hinges largely upon the physician's ability to keep confidential those matters which he may manage effectively without knowledge or intervention of the family, and of course this very fact places a great responsibility upon the professional. Nevertheless, I never promise to the adolescent patient an unqualified confidentiality, and openly reserve the right to share critical information with *anyone* (and especially family members) if the occasion demands it. Usually those occasions are fairly uncommon, but when they do occur I first inform the patient that I must share private information with someone else, and then I take considerable pains to explain why I must do so. This reservation keeps the parents in particular informed and working with the professional should such vital issues as self-destructive behavior be involved. In my experience I have never seen the patient openly resent such an action on my part, and in fact they will often share their more desperate thoughts or plans with me knowing full well that I *must* include others in the plan for rescue.

(2) The principle of a family's relinquishing all its rights of information or control over an adolescent simply doesn't make sense, unless of course the truly adversarial family is identified, and in my opinion this goes even for the professional insofar as he assumes that control. Furthermore, it would seem the right of the family to know the basic operating principles of the professional involved in the care and treatment of their teenager, and in my definition this should include a knowledge of his moral and religious principles as well as his protocol for managing some of the touchier issues of adolescence, such as the ones mentioned in your recent letter. The *technique* of management loses a great deal of its threat when the family is aware of the physician's or counselor's operating *principles*, and indeed I would personally be very suspicious of any professional who would not be willing to state those principles or who simply has no convictions upon which to operate. With full communication between professional and family, a much more solid feeling of trust in management of their teenager should ensue, and confidentiality could be better maintained without fear of moral or ethical violation.

It would seem that if these two considerations were held as valid, the rights of the family, the adolescent, and his professional caretaker would all be equally considered and honored, and the constant debate over just who should be in control would subside. Such consideration for all parties would also tend to facilitate much better adolescent health care and counseling (due to the independent strivings of the youngster as well as his desire to restrict communication with close family members), and the physician-patient relationship could be preserved without completely destroying the rights of parents (God-given rights in my opinion!) to help their child through a personal crisis.

I hope this concept is of some help to you, Senator Denton. I applaud your efforts to preserve family unity, and hope that all legislation directed at the adolescent will consider this factor as paramount, unless there be clear evidence that the teenager is simply to be protected from all forces outside the territory of professional control. In my experience this is the exception rather than the rule.

Sincerely yours,

W A Long Jr MD

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William A. Long, Jr., M. D.

CURRICULUM VITAE

Name: William Alexander Long, Jr. Date of Birth: April 20, 1930

Place of Birth: Gallman, Mississippi Religion: Presbyterian

Formal Education:

Elementary School	Gallman Elementary School, Gallman, Miss.	1935-43
High School	Gallman High School, Gallman, Miss.	1943-44
	Hazlehurst High School, Hazlehurst, Miss.	1944-47
College	University of Mississippi, University, Miss.	1947-49
	Millsaps College, Jackson, Miss.	SS 1948
	Tulane University, New Orleans, La. (B. S.)	1949-51
Medical School	Tulane University, New Orleans, La. (M. D.)	1951-55
Internship	Colorado General Hospital, Denver, Colo.	1955-56
Pediatrics Residency (Adolescent Medicine)	Colorado General Hospital, Denver, Colo.	1965-67

Military Service: United States Air Force
School of Aviation Medicine, Randolph AFB, San Antonio, Tex., 1956.
Flight Surgeon, Ladd AFB, Fairbanks, Alaska, 1957-58.

Private Practice Experience:
General Practice, Gulfport, Miss., 1958-61.
General Practice, Denver, Colo., 1961-65.
General Pediatrics & Adolescent Medicine, Denver, Colo., 1967-69.
Adolescent Medicine, Jackson, Miss., 1969-82.

Professional Teaching Appointments:
Lecturer in Pediatrics, University of Colo. School of Nursing, 1966-67.
Assistant in Pediatrics (Adolescent Medicine), University of Colo. School of Medicine, 1966-67.
Instructor in Pediatrics (Adolescent Medicine), University of Colo. School of Medicine, 1967-69.
Clinical Instructor in Pediatrics (Adolescent Medicine), University of Miss. School of Medicine, 1969-74.
Clinical Assistant Professor of Pediatrics (Adolescent Medicine), University of Miss. School of Medicine, 1974-82.
Attending Physician, University Hospital, Jackson, Miss., 1969-82.

States Licensed to Practice: Mississippi & Colorado.

Hospital Staff Appointments:
Mississippi Baptist Medical Center
Doctors Hospital of Jackson
University of Mississippi Medical Center
Jackson-St. Dominic's Hospital

Professional Societies & Organizations:
Diplomate, National Board of Medical Examiners
Diplomate, American Board of Pediatrics
Fellow, American Academy of Pediatrics
Society for Adolescent Medicine
Central Medical Society
Mississippi State Medical Association
American Medical Association

Fraternal Organizations:
Pre-medical Honorary: Phi Eta Sigma, Alpha Epsilon Delta.
Medical Honorary: Alpha Omega Alpha.
Social: Phi Delta Theta, Phi Chi.

Professional Committee Appointments & Duties:
Chairman, Youth Committee, Colorado Chapter, American Academy of Pediatrics, 1968-69.
Professional Advisory Committee, Hinds County Association for Mental Health, 1970-77.
Committee on Mental Health, Mississippi State Medical Association, 1971-73.
Chairman, Youth Committee, Mississippi Chapter, American Academy of Pediatrics, 1969-82.
Mississippi Foundation for Medical Care: Psychiatry Criteria Review Panel, 1975-77.
Chief, Department of Medicine, Doctors Hospital of Jackson, 1975-76.
Secretary, Department of Pediatrics, St. Dominic's Hospital, 1975-76.
Executive Board, Central Medical Society, 1971.
Executive Council, Society for Adolescent Medicine, 1973-75.
Chairman, Nominations Committee, Society for Adolescent Medicine, 1976.
Private Practice Committee, Society for Adolescent Medicine, 1976-77.
Chairman, Private Practice Committee, Society for Adolescent Medicine, 1977-81.
Chairman, Ad Hoc Committee on Fellowship Status, Society for Adolescent Medicine, 1981-82.
Nominations Committee, Society for Adolescent Medicine, 1982-83.
Charter Member, Section on Adolescent Health Care, American Academy of Pediatrics, 1979-82.
Chairman, Nominations Committee, Section on Adolescent Health Care, American Academy of Pediatrics, 1980-81.
Committee on Adolescence, American Academy of Pediatrics, 1977-80.
Chairman, Committee on Adolescence, American Academy of Pediatrics, 1980-82.

Service Clubs & Community Affairs:
Jackson Rotary Club, 1969-73.
Board of Directors, 1972-73.
Chairman, Youth Committee, District 682, Rotary International, 1972-73, 1976-77.
Juvenile Delinquency Advisory Council, Mississippi State LEAD, 1969-71.
Chairman, Executive Board, Youth Crisis Centers, Inc., 1971-75.
Board of Directors, United Givers Fund, 1972-74.
Board of Directors, Willowood Developmental Center, 1975-79.

Church Affiliation:
First Presbyterian Church, Jackson, Miss.
Deacon, 1971-75.
Ruling Elder, 1975-79.

Special Awards:
Liberty Bell Award, Hinds County Junior Bar Association, 1971.
Service to Mankind Award, Southwest (Jackson) Sertoma Club, 1972.
Service to Mankind Award, Mississippi District, Sertoma International, 1972.
Robins Award for Outstanding Community Service by a Physician (Mississippi State Medical Association), 1973.

Publications:

"Adolescent Medicine: an Approach through Private Practice". *Pediatric Annals*: Volume 2, Number 6, pages 70-78. June 1973.

"Adolescent Maturation: a Clinical Overview". *Postgraduate Medicine*: Volume 57, Number 3, pages 54-60. March 1975.

"Transitions Interview". *Transitions*: Volume 2, Number 4, pages 12-13. July 30, 1979.

"Managing the Suicidal Adolescent". Suicide Attempts in Children and Youth: edited by Matilde S. McIntire and Carol R. Angle. Harper & Row, 1980. Chapter 5, pages 64-69.

Speaking and Teaching Engagements:

American Academy of Pediatrics: Spring Session, Seminar Leader, April 1977. New Orleans, Louisiana.

Department of Health, Education and Welfare: Adolescent Health Care Workshop, Workshop Participant and Discussion Leader, June 1977. Birmingham, Alabama.

Colorado Academy of Family Physicians: Visiting Faculty Member, July 1978. Vail, Colorado.

Pensacola Educational Conference: Visiting Faculty Member, September 1978. Pensacola, Florida.

Interstate Postgraduate Medical Association of North America: Scientific Assembly, Visiting Faculty Member, November 1974. Hollywood, Florida.

Florida Pediatric Association: Visiting Faculty Member. November 1973. Hamilton, Bermuda.

American Academy of Pediatrics: Fall Session, Seminar Leader, October 1978. Chicago, Illinois.

Fitzsimons Army Medical Center: Guest Professorship, November 1979. Denver, Colorado.

Madigan Army Medical Center: Guest Professorship. September 1980. Tacoma, Washington.

American Academy of Pediatrics: Fall Session, Plenary Session Speaker and Informal Discussion Group Leader, Detroit, Michigan. October 1980.

American Academy of Pediatrics: Postgraduate Course Lecturer, January 1981. Sun Valley, Idaho.

American Academy of Pediatrics: Postgraduate Course Lecturer, May 1981. Santa Fe, New Mexico.

William Beaumont Army Medical Center: Guest Professorship, May 1981. El Paso, Texas.

Great Smoky Mountains Pediatric Society: Adolescent Seminar Lecturer, June 1981. Gatlinburg, Tennessee.

Omaha Childrens Memorial Hospital: Adolescent Seminar Lecturer. September 1981. Omaha, Nebraska.

East Carolina University School of Medicine: Visiting Professorship, February 1982. Greenville, North Carolina.

Baptist Memorial Hospital: Adolescent Medicine Seminar Lecturer, May 1982. Kansas City, Missouri.

Society for Adolescent Medicine: Advanced Seminar on Private Practice, Leader and Panel Chairman, October 1982. New York, New York.

American Academy of Pediatrics: Fall Session, Roundtable Leader and Informal Discussion Group Leader, October 1982. New York, New York.

Senator DENTON. Thank you very much, gentlemen.

Thank you very much, ladies and gentlemen.

We stand adjourned.

[Whereupon, at 2:35 p.m., the subcommittee was adjourned.]

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